

1 STATE OF ILLINOIS
2 HEALTH FACILITIES AND SERVICES REVIEW BOARD
3 525 West Jefferson Street, 2nd Floor
4 Springfield, Illinois 62761
5 217-782-3516
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11 LONG-TERM CARE ADVISORY SUBCOMITTEE
12 MEETING

13 The meeting of the State of Illinois Health Facilities
14 and Services Review Board, Long-Term Care Advisory
15 Subcommittee was held on February 19, 2013, scheduled to
16 begin at the hour of 10:00 a.m., at Bolingbrook Golf Club,
17 2001 Rodeo Drive, Bolingbrook, Illinois.
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1 MEMBERS PRESENT:

Michael Waxman - Chairman
2 Gerry Jenich (proxy for Eli Pick)
Kristen Pavle (proxy for Phyllis Mitzen)
3 Michael Scavotto
Carolyn Handler
4 David Raikes
Cece Credille
5 Neyna Johnson
Toni Colon
6 Tim Phillippe
Greg Will (proxy for Dave Lowitzki)
7 Terry Sullivan
Pat O'Dea Evans

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ALSO PRESENT:

11 Courtney Avery - HFSRB Administrator
Frank Urso - Legal Counsel
12 Juan Morado - HFSRB Staff
Cathy Clarke - HFSRB Staff
13 Claire Burman - HFSRB Staff
George Roate - HFSRB Staff
14 Mike Constantino - HFSRB Staff
Bill Dart - IDPH
15 Alexis Kendrick - HFSRB Staff

16

ALSO PRESENT:

17 Charles Foley
Chuck Sheets
18 John Florina
Joe Ourth
19 Jason Speaks

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21 Reported by:

Karen K. Keim

22 CRR, RPR, CSR-IL, CRR-MO
Midwest Litigation Services
23 401 N. Michigan Avenue
Chicago, IL 60611

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1 AGENDA

2 1. Roll Call

3 2. Approval of Proxy

4 3. Approval of Agenda

5 4. Approval of December 3, 2012 and February 4, 2013

Meeting Minutes

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7 5. Annual Ethics Training

8 6. Statement of Economic Interest

9 7. CON Application Workgroup Report and Discussion

10 8. Bed Sell/Exchange RFP Workgroup Report and Discussion

11 9. Long-Term Care Reforms

Change of Ownerships; Discontinuations; and

12 Addressing Underutilized LTC Beds

13 10. Other Business

14 11. Next Meeting

15 12. Adjournment

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1 START TIME: 10:07 a.m.

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3 CHAIRMAN WAXMAN: We'd like to call the
4 meeting to order, please, if people would grab a seat and
5 settle in.

6 All of the other preliminary business is taken
7 care of. We believe we have a quorum. We believe we have
8 a lot of people. Is everybody in the right place?

9 Ms. Court Reporter, are you good?

10 We'll call the roll by going around the room
11 and introducing yourself.

12 MS. CREDILLE: Cece Credille, representative
13 of Illinois Healthcare association.

14 MS. HANDLER: Carolyn Handler, Rainbow Hospice
15 and Palliative Care.

16 MS. JOHNSON: Neyna Johnson, Long-Term Care
17 Ombudsman Program.

18 MR. SULLIVAN: Terry Sullivan, Alliance for
19 Living, and the Illinois Nursing Home Administrators
20 Association.

21 MR. PHILLIPPE: Tim Phillippe, Christian
22 Homes, a not-for-profit provider.

23 MR. SHEETS: Chuck Sheets; I'm an attorney
24 representing a lot of long-term care facilities and also

1 the HCCI Association.

2 CHAIRMAN WAXMAN: Chuck, you're here as a
3 visitor?

4 MR. SHEETS: Correct.

5 MR. FOLEY: Charles Foley, healthcare
6 consultant.

7 CHAIRMAN WAXMAN: And, Chuck, you're here as
8 a visitor. I'm distinguishing, because we have some
9 proxies.

10 MR. FLORINA: John Florina; I'm also here as a
11 visitor. I'm a nursing home administrator.

12 MR. SCAVOTTO: Michael Scavotto, committee
13 member.

14 MR. JENICH: Gerry Jenich with NuCare
15 Services.

16 CHAIRMAN WAXMAN: And Gerry is representing
17 Eli's role.

18 MR. RAIKES: Good morning. David Raikes with
19 Laborers Local Union in Marseilles.

20 CHAIRMAN WAXMAN: I'm Mike Waxman, Chair.

21 MS. AVERY: I'm Courtney Avery, Planning Board
22 Staff.

23 MR. URSO: Frank Urso, Counsel to the Board.

24 MR. DART: Bill Dart, Department of Public

1 Health.

2 MS. KENDRICK: Alexis Kendrick, Board Staff.

3 MR. CONSTANTINO: Mike Constantino, Board

4 Staff.

5 MR. SPEAKS: Jason Speaks, LSN.

6 MS. PAVLE: Kristin Pavle. I'm here as a

7 proxy for Phyllis Mitzen. Good morning.

8 MR. OURTH: Joe Ourth, visitor with the law

9 firm of Arnstein and Lehr.

10 MS. BURMAN: Claire Burman, Board Staff.

11 MR. MORADO: Juan Morado, Board Staff.

12 MR. ROATE: George Roate, Board Staff.

13 MR. WILL: Greg Will, SEIU, here as a proxy

14 for Dave Lowitzki.

15 CHAIRMAN WAXMAN: Thank you. I need Board

16 approval for the two proxies -- well, those that are new to

17 the group, Jerry and Kristin, please.

18 MR. PHILLIPPE: So moved.

19 MR. RAIKES: Second.

20 CHAIRMAN WAXMAN: All in favor?

21 ("Ayes" heard)

22 CHAIRMAN WAXMAN: Any opposed?

23 (No response)

24 CHAIRMAN WAXMAN: Motion carries. So, again,

1 we appreciate you taking your time out of the day to serve
2 on this committee, and as the rules allow, you are able to
3 vote, if we are in a voting situation.

4 Need a motion to approve today's agenda. Does
5 everyone have today's agenda? Anyone not have today's
6 agenda?

7 (Pause)

8 CHAIRMAN WAXMAN: I need a motion to --

9 MS. HANDLER: So moved.

10 CHAIRMAN WAXMAN: I need a second.

11 MS. CREDILLE: Second.

12 CHAIRMAN WAXMAN: Have a motion; have a
13 second. All in favor?

14 ("Ayes" heard)

15 CHAIRMAN WAXMAN: Okay. Motion carries.

16 Is there anyone from the public that wishes to
17 address the Board, any public comment from --

18 MR. URSO: Excuse me, Mr. Chair. We need to
19 make a change on the agenda. I think that we've -- we were
20 just talking about approving it a couple minutes ago.

21 Statement of Economic Interest, Number 6, is not going to
22 be a topic that this committee is going to deal with.

23 CHAIRMAN WAXMAN: Okay. So I need a motion to
24 approve the agenda as amended.

1 MR. SULLIVAN: So moved.

2 MR. PHILLIPPE: Second.

3 CHAIRMAN WAXMAN: All in favor?

4 ("Ayes" heard)

5 CHAIRMAN WAXMAN: Motion carries.

6 I need -- can we approve both minutes in one
7 motion?

8 MR. URSO: As long as you identify that you're
9 doing that, specify it.

10 CHAIRMAN WAXMAN: Well, I guess the question
11 is, does anyone have any changes to either set of minutes?
12 Otherwise, we will approve them in one motion. Anyone have
13 any changes to either set of minutes?

14 (Pause)

15 CHAIRMAN WAXMAN: Hearing none, I will accept
16 a motion to approve the minutes of December 3rd and
17 February 4th. February 4th was a conference call.

18 MR. SCAVOTTO: I make that motion.

19 MR. RAIKES: Second.

20 CHAIRMAN WAXMAN: All in favor?

21 ("Ayes" heard)

22 CHAIRMAN WAXMAN: Any opposed?

23 (Pause)

24 CHAIRMAN WAXMAN: Motion carries. Okay. We

1 should be out of here by 10:30.

2 (Laughter)

3 MS. HANDLER: Mr. Chairman, I would like to
4 ask, is there any way for Staff to do an executive summary
5 of the transcripts, so that it's a little more efficient
6 for Board members or Committee members to actually review?

7 MS. AVERY: Yes, we can do that, just hitting
8 the main points --

9 MR. PHILLIPPE: Great.

10 MS. AVERY: -- with just the outcomes?

11 MS. HANDLER: Um-hum.

12 MS. AVERY: Okay. But the transcripts will
13 still be distributed. Okay.

14 CHAIRMAN WAXMAN: Okay. Staff now has its
15 first assignment. I love it.

16 MS. HANDLER: Thank you.

17 CHAIRMAN WAXMAN: Frank, are you in charge of
18 the annual ethics training?

19 MR. URSO: Yes, I am.

20 CHAIRMAN WAXMAN: You are collecting money for
21 doing this?

22 MR. URSO: Invoices are in the mail.

23 CHAIRMAN WAXMAN: Seems ethical to me.

24 (Laughter)

1 MR. URSO: As is done every year, ethics
2 training needs to be completed by all of the Long-Term Care
3 Subcommittee members. That includes proxies who come in
4 and out of various meetings; and Cathy is going to be
5 handing out the training materials. You'll see a cover
6 letter there, and you'll also see the actual ethics
7 training materials below that. The last page, there's
8 going to be an Acknowledgement or Certificate of
9 Completion. You need to sign that and return the original
10 back to Cathy or myself. This is not something you're
11 going to have to do today. We have a deadline of, I
12 believe, April 1st. Is that what we have in the cover
13 letter, Cathy, April 1st?

14 MS. CLARKE: Yes.

15 MR. URSO: So, if you want to mail it back or
16 call us, drop it off, or whatever; but we need to have the
17 original back page back, signed off, after you review the
18 materials. If you have any questions while you're going
19 through this, please don't hesitate to contact me, and
20 we'll try to get all of your questions answered. We need
21 to have the originals back, the original sign-off sheet.
22 Any Long-Term Care Subcommittee members have a question?

23 MR. PHILLIPPE: We can scan it and send it in?

24 MR. URSO: You mean the page?

1 MR. PHILLIPPE: The final page; or do we have
2 to have the original mailed in?

3 MR. URSO: I would say so. If you could do
4 that, that would be fine.

5 CHAIRMAN WAXMAN: Point of clarification:
6 So, anyone who is sitting here as a proxy needs to do this?

7 MR. URSO: Yes.

8 CHAIRMAN WAXMAN: And what about proxies -- I
9 asked if people sitting in as proxies today need to do it,
10 and Frank said yes, and then I asked if proxies of the past
11 had to do it.

12 MR. URSO: And I would say yes, especially if
13 they're going to be coming back at some point in time even
14 if they're not sure of what date that would be. I would
15 say we need a list of those names, if we don't already have
16 them, and we would send them the material so they can
17 complete it.

18 CHAIRMAN WAXMAN: So Staff will take care of
19 that?

20 MR. URSO: Cathy, did you hear that? Proxies
21 that are not here, we have to contact them to get them the
22 material.

23 MS. CLARKE: Yes.

24 CHAIRMAN WAXMAN: Moving on, were there any

1 other questions about ethics?

2 (No response)

3 CHAIRMAN WAXMAN: Okay. CON Application
4 Report. Mike, I guess that's under your --

5 MR. SCAVOTTO: We've been through four
6 conference calls and reviewed the application. There are
7 follow-up items that we need to get in.

8 George, I know you're working on something.

9 Claire, you've got some follow-up.

10 Frank, I talked to you this morning.

11 And there's a bunch of things that, Courtney,
12 you need to get together with your staff on.

13 And once we get that follow-up -- once you get
14 it done, get it to Courtney so she can get it to me, we can
15 start the process all over again, and what we're trying to
16 figure out -- we think we've got established the changes
17 that we can make administratively, and then there are
18 changes that would require going through the legislative
19 process. So, that's, in a nutshell, where we are. There
20 won't be any more conference calls until we get the
21 follow-up. There won't be anything to talk about without
22 the follow-up materials.

23 CHAIRMAN WAXMAN: So, if I remember
24 correctly, we have revised an application and put it into

1 place?

2 MR. SCAVOTTO: And we're looking that over.

3 CHAIRMAN WAXMAN: And now we are reviewing it
4 with the question of the application that we have sent for
5 use now to determine what can be changed by this committee
6 versus what has to be changed -- or what we would like to
7 be changed, that representatives will change, that has to
8 go to the Mother Board. So, everybody clear on that
9 process? And in order for the committee to finish its
10 work, Staff -- various assignments are in Staff's hands.

11 MR. SCAVOTTO: That's correct.

12 CHAIRMAN WAXMAN: Can you give the committee
13 an approximate date when you might have everything; or is
14 that an impossible question?

15 MS. AVERY: I think we were thinking it would
16 be presented for the conference call that was canceled.

17 MR. SCAVOTTO: I'd like to get a conference
18 call set up quickly. So, hearing from you on the follow-up
19 items should be a prerequisite to doing that.

20 MS. AVERY: First week in March?

21 MR. SCAVOTTO: Yeah, we'll make that work.

22 MS. AVERY: We'll schedule it.

23 CHAIRMAN WAXMAN: Are we expecting someone to
24 call in?

1 MS. AVERY: No. I think I requested the phone
2 when Phyllis wanted it, but then she had Kristin come.

3 CHAIRMAN WAXMAN: Okay. So that's the status
4 on that.

5 The next is Bed Sell/Exchange Workgroup
6 Report, and I'm not sure who is -- Terry?

7 MR. SULLIVAN: It's Cece, me, and Eli.

8 CHAIRMAN WAXMAN: Eli is not here, so the two
9 of you are on your own.

10 MR. SULLIVAN: Okay. I am passing out
11 something that Courtney just gave me. We've had a couple
12 of conference calls, based on the vote of this committee
13 that we pursue some kind of independent impact analysis of
14 the idea of bed relocation programs based on other states;
15 and, of course, the starting point is Claire's outstanding
16 work in investigating what other states are doing, and we
17 know the regulatory impact of buy/sell in other states and
18 what those programs look like. There was a sense, I think,
19 from some of the Staff and some of the committee of we'd
20 really like to know the experience of other states, getting
21 more of an intuitive sense of whether the -- a bed
22 relocation program has a positive or a negative effect;
23 what are some of the unintended consequences? But get more
24 of a feel, not just a regulatory report of what happened,

1 because I think the big question is, what kind of impact is
2 a bed relocation program going to have upon the system here
3 in Illinois? So, I think that's the question that was
4 going forward.

5 I think the Staff suggested that we not do a
6 gigantic RFP but, in fact, work together with some of the
7 universities here in Illinois and put out a letter to them,
8 saying, "Would you be interested in doing an impact
9 analysis?" Hopefully, sometime in the next six months
10 would be our goal, and have that reported back to both this
11 subcommittee and the Mother Board.

12 And so, are there -- first of all, any
13 questions about where we're at with that and the sense of
14 where this committee wants to go with it?

15 CHAIRMAN WAXMAN: I have a sense that
16 Mr. Foley has something to say.

17 MR. FOLEY: No, that's all right. Thank you,
18 Michael. I'll save my comments.

19 CHAIRMAN WAXMAN: Okay.

20 MR. SULLIVAN: I'd like to make a motion that
21 this letter developed by the Staff be the basis of a
22 request to several of the Illinois universities, to see if
23 they want to work in collaboration with the Planning Board
24 and this subcommittee, in doing an impact analysis of bed

1 relocation from other states.

2 CHAIRMAN WAXMAN: Chuck is reconsidering. I
3 can see it in his face.

4 MR. FOLEY: I guess my concern is the outcome
5 of this in terms of the timeline, because, obviously, the
6 feedback at least I've been hearing is that, "Gosh, if
7 we're going to do this buy/sell program, why can't we do it
8 right away?" So, it looks like that we could be over here
9 a ways from this yet, and I don't see any reason as to why
10 we cannot just go ahead and put together policies, if we
11 want to do this, and just go ahead and implement it, and
12 save ourselves some money, and see if it's going to work in
13 Illinois. I don't see, really, an advantage of waiting six
14 months to have somebody come back with an RFP and then they
15 go through the research. In six months, this is something
16 we could already have a program implemented, hopefully. I
17 don't think it's going to be that big of a deal to
18 implement such a program, unless I'm reading it wrong.

19 Terry, help me.

20 MR. SULLIVAN: I'm waiting for Mr. Waxman.

21 CHAIRMAN WAXMAN: Sorry.

22 MR. SULLIVAN: You speak very eloquently.

23 And so, Mr. Waxman, I'm in the uncomfortable
24 position of agreeing with him totally.

1 MR. PHILLIPPE: Maybe I could say something.

2 MR. SULLIVAN: I know there's a sense in the
3 committee that it would be good to have an impact analysis
4 from the other states that are doing this.

5 MR. PHILLIPPE: Some states that we looked at
6 had a negative impact. I think Claire found that they were
7 very happy with it. I was part of a long discussion on
8 this for a while -- a different work group -- and there
9 were people in this group that wanted to know what was
10 going to happen, to be able to predict the impact rather
11 than just trying it and see what happened. Is that kind
12 of --

13 MR. SULLIVAN: That sums it up.

14 MR. FOLEY: You're absolutely correct in your
15 summation, and it has been talked about, but then again, I
16 really don't see a problem -- I haven't heard an answer
17 yet -- the problem of just going to proceed on our own. I
18 don't know what somebody is going to come out from the
19 outside to tell us about the impact, which could be a year
20 from now. We could know that ourselves within a year.
21 This is a very important issue for the state of Illinois,
22 is what I'm trying to say. A lot of providers out there,
23 you know, are hurting right now and suffering right now.
24 They have empty beds right now, essentially, they want to

1 sell. What I'm saying is, gosh, if we're going to do it,
2 let's just go ahead and do it. I don't see the reason to
3 hold back on it.

4 CHAIRMAN WAXMAN: Hold on. You need to be
5 recognized by the Chair.

6 Second of all, I have a housekeeping task. We
7 have a new member. Would you --

8 MS. O'DEA-EVANS: I'm an old member but I'm
9 late, a late member.

10 CHAIRMAN WAXMAN: So, for the minutes --

11 MS. O'DEA-EVANS: Patricia O'Dea Evans.

12 CHAIRMAN WAXMAN: Thank you, Pat. You may --

13 MS. PAVLE: I was going to say, it sounds like
14 the purpose of this would serve a planning function, that
15 it would look at how we could implement such a program in
16 Illinois and decide best practices based on other people's
17 experience. So, instead of jumping in and saying, "Well,
18 this is how we want to do it and this is how we think it
19 should be done," looking at other people's experiences, in
20 order to plan, which I think is the intent of planning
21 boards --

22 MR. FOLEY: We have that information already,
23 as Tim had alluded to. We know what other states have
24 done. We know what the good points are and the bad points

1 are. So.

2 MS. PAVLE: So, we already have a report?

3 MR. FOLEY: I don't think it's in the form of
4 a report, is it, Terry?

5 MR. SULLIVAN: It's an excellent report. Goes
6 state by state, has every single detail.

7 MS. HANDLER: But the report does not apply to
8 an impact to the state. It's a summary of all of the
9 different practices across the country with benefits,
10 perhaps, or some of the drawbacks those states have
11 experienced, but it doesn't take that and say, "If we do
12 that in Illinois, this is what could potentially happen."

13 CHAIRMAN WAXMAN: I saw Mike's hand.

14 MR. SCAVOTTO: My recollection of the
15 discussion is a little bit different; and my recollection
16 is that there wasn't a lot of opposition to trying this in
17 Illinois. But from a practical standpoint, I thought that
18 we had to go through a legislative process to get this
19 implemented.

20 Am I correct in that, Courtney?

21 MS. AVERY: Correct.

22 MR. SCAVOTTO: And I want to say that the
23 thinking from the Staff was that you'd have a much better
24 chance of getting this through the legislative process if

1 we had some independent research and backing, and that's
2 the whole reason behind this RFP thing.

3 Do I recall that correctly?

4 MS. AVERY: That's correct. And, also, I
5 wanted to remind you that we won't be behind, because the
6 legislation that empowered us to do this, to evaluate the
7 bed sell/exchange program doesn't start until August of
8 this year. So we're actually ahead. We're ahead. We
9 won't be delayed in any way.

10 CHAIRMAN WAXMAN: I saw -- you did have your
11 hand up.

12 MR. WILL: Yeah. I think, though, that
13 Carolyn addressed my point, which was just to distinguish
14 that we have a pretty thorough survey of things in other
15 states, but not a report of any kind of findings that we
16 would want. That's all.

17 CHAIRMAN WAXMAN: Okay. Terry?

18 MR. SULLIVAN: Courtney, I just wanted to
19 clarify. We don't need additional legislation at this
20 point? We have all of the authority we need, right?

21 MS. AVERY: Right. But it was the authority
22 to begin to evaluate a bed sell and exchange program for
23 the state of Illinois.

24 CHAIRMAN WAXMAN: Chuck?

1 MR. SHEETS: I just wanted to clarify that
2 the legislation becomes effective in August, and the
3 concept was that the committee would be working on this the
4 entire time before it became effective.

5 MS. AVERY: And we have been. So, we're
6 really ahead. We have some other information that's out
7 there, but.

8 MR. SHEETS: Right, but it sounds like this
9 would further delay --

10 MS. AVERY: No, I don't think it would.

11 MR. SHEETS: -- the implementation.

12 MS. AVERY: I hear that a lot, but I'm not
13 understanding how, because the legislation is to evaluate,
14 not to implement yet. So this is kind of the thrust to see
15 if it's good for the State of Illinois to implement that
16 type of program.

17 CHAIRMAN WAXMAN: Tim?

18 MR. PHILLIPPE: I appreciate what you're
19 saying, because that corrected an error on my part. I
20 thought the legislation in the past gave the Board
21 authority to do it. What you're saying is it gave the
22 Board authority to evaluate. So, it's going to take
23 additional legislation to implement it.

24 MS. AVERY: When we began to work with the --

1 I think it was HCCI. When we began to work with them, the
2 long-term care industry.

3 MR. PHILLIPPE: Part of it.

4 MR. URSO: The legislation does say it's an
5 evaluation at this point in time.

6 CHAIRMAN WAXMAN: Kristen?

7 MS. PAVLE: I'm just curious about postponing
8 something, that it's in our best interests to look through
9 something fully before acting. And I understand that a lot
10 of providers are hurting, but in order to make the big
11 change, I think it would make sense to go through, like I
12 said, some sort of analysis and planning and thinking about
13 this comprehensively before acting. So, I'm hearing that
14 it would delay things, but I don't see how that is the
15 worst thing that could happen from this.

16 CHAIRMAN WAXMAN: Unless I'm hearing it
17 wrong, I don't think anyone is suggesting postponing. I
18 think they're suggesting that the committee move forward
19 without anybody -- without outside help. Is that what I'm
20 hearing, or am I hearing it wrong?

21 MS. CREDILLE: You're hearing it correctly.
22 We were moving forward, until the Staff suggested that we
23 needed to go through the RFP process at the October
24 meeting, and then it was on a conference call in January

1 that I participated in that it was suggested that the RFP
2 process is not a reasonable process, because it would
3 potentially delay and we didn't need to do that. So now
4 we're back to this.

5 So, my recollection is, it was at the
6 recommendation of the Staff that we stop, do the RFP; and
7 then it was the recommendation from someone at the
8 Department of Public Health and the Staff that the RFP
9 wasn't going to work, that we needed to put it out to the
10 universities. So it seems like a delay --

11 MR. DART: Cece, I was the Staff that
12 recommended change from the RFP. It was actually to move
13 things more quickly, because an RFP process is a very
14 lengthy process for the State Agency, whereas we have means
15 to acquire services from a university much more
16 expeditiously. So that was the change, to working with.

17 MS. CREDILLE: I was a "no" vote in October
18 for the RFP on behalf of IHCA, because it was going to
19 delay the process. There were not very many "no" votes,
20 and I was one of the "no" votes for that simple reason.

21 CHAIRMAN WAXMAN: Again, housekeeping. Toni
22 Colon is with us.

23 MR. PHILLIPPE: Can I just clarify? I think I
24 missed a meeting when I had surgery a few months ago --

1 CHAIRMAN WAXMAN: People's memories are
2 fading.

3 MR. PHILLIPPE: -- because it seems to me that
4 we're confused and we're talking across. I think when you
5 talk about delay, that's because -- the one meeting I came
6 to before, we actually came up with the RFP idea. I
7 thought a lot of us thought we could take the
8 recommendation to the Board and the Board had the authority
9 to do this pilot we were talking about. It's not clear to
10 me if that's part of studying or that's -- but if it really
11 would take legislative action to do anything, we're not
12 talking about delay here, right? If it takes legislative
13 action to actually implement anything, then it sounds like
14 an analysis by a university would not really delay us. But
15 I think awhile back, people thought we could actually just
16 come up with a plan -- I remember looking at plans, the
17 idea to implement -- and then those could be a pilot and
18 those were to be tested.

19 So, could somebody on the legal side just
20 clarify. Would we be able to do that -- which people think
21 it is being a delay -- or we're not able to do that anyway?
22 We still have to go back to the Legislature and it's going
23 to take awhile to do anything?

24 CHAIRMAN WAXMAN: The legal side is you,

1 Frank.

2 MR. PHILLIPPE: I think there's confusion,
3 really, in what we're allowed to do, in what the Board is
4 allowed to do.

5 MR. FOLEY: I thought we were talking about
6 this was supposed to start around January of this year.
7 This is when we were talking about it mid-year last year,
8 and try to get something going by January of this year, and
9 even then, there was discussion that, god, that's still a
10 long time, from back then that is. So here we are in
11 February already and we still haven't done anything yet.

12 MR. PHILLIPPE: But the question is, what is
13 the law? What is the Board allowed to do? That would
14 help, in knowing that.

15 MR. URSO: I can tell you specifically. In
16 the Health Facilities Planning Act, Section 12, it gives
17 this Subcommittee authority to evaluate, to make
18 recommendations to the State Board regarding buying,
19 selling and exchange of beds between long-term care
20 facilities within a specified geographic area or drive
21 time. So, the Subcommittee shall evaluate and make
22 recommendations to the Board, to the State Board. That's
23 the authority. That's the authority this committee has.

24 CHAIRMAN WAXMAN: Chuck?

1 MR. SHEETS: Maybe a little history would
2 clarify this for everybody. I was also involved -- because
3 I'm counsel for HCCI -- with Courtney and discussions on
4 the bill, and, essentially, what happened was, the industry
5 wanted this to happen, and the response back from the
6 Board -- and I don't know if this was Frank; it probably
7 was, but I don't know for sure -- was that there wasn't
8 authority to do that under the existing statute. So the
9 conversation that I was involved in was, "Well, we need to
10 give the Board the authority to do that." And it's my
11 recollection, the Board's concern was, "Well, it's going to
12 take some time to implement this." So there was a later
13 effective date put on the authority, and this is supposed
14 to be the authority to do it.

15 So, there's definitely a disconnect between
16 the industry and the Board, if the Board doesn't feel that
17 this is authority enough; and I'm sure that the Association
18 will go back and try to get more, if that's what the Board
19 feels.

20 CHAIRMAN WAXMAN: You're talking Mother
21 Board?

22 MR. SHEETS: Correct.

23 MS. AVERY: And part of our discussion, when
24 we were talking about implementing the program and the

1 pilot and the recommendations for the RFP, came out that to
2 have something concrete to present to the Board, we felt
3 that that would give more of an evidence base, whether the
4 Board should go forth with this or not. Is it good for the
5 State of Illinois? Is it good for residents who are using
6 the long-term care? How would it look? Where would we
7 exchange beds? Would it be between HSA's, county? All of
8 those questions were left up in the air, and I didn't feel
9 that we had the expertise on our staff or the resources at
10 that time to do that, which is how the RFP was recommended
11 to the Board, in order to have that concrete evidence, not
12 just to say "Okay. Well, let's do it haphazardly." What
13 are the boundaries? What are the drive times? It takes a
14 lot of time.

15 I understand the urgency from the industry to
16 do this, but in the best interests of the Board, the State
17 and the residents, I just didn't feel like we had enough
18 information to go forth with a pilot.

19 CHAIRMAN WAXMAN: Terry?

20 MR. SULLIVAN: I have a motion on the table
21 that we move forward with this expeditiously.

22 CHAIRMAN WAXMAN: We don't have a second for
23 that motion.

24 MR. PHILLIPPE: I'll second.

1 MR. URSO: Can you just explain what you mean
2 by "this", so it's clear on the record.

3 MR. SULLIVAN: I had made a motion before
4 Mr. Foley spoke up to adopt the essential elements of this
5 letter, to move forward in discussion with Illinois
6 universities to do an impact analysis of other states,
7 based on Claire's research.

8 MS. PAVLE: Just the basic elements as it is
9 now? Because I think there's certain things in here that I
10 would recommend potentially changing or just worth bringing
11 up for further discussion.

12 CHAIRMAN WAXMAN: Then you're changing his
13 motion.

14 MR. SULLIVAN: Well, let's say the motion has
15 the essential elements. We can certainly talk about what
16 goes in the letter. It does not have to be exactly word
17 for word as it's presented here.

18 CHAIRMAN WAXMAN: So, your motion is open
19 to --

20 MR. SULLIVAN: -- change.

21 CHAIRMAN WAXMAN: -- changes?

22 MR. SULLIVAN: Word changes, yes.

23 CHAIRMAN WAXMAN: But not conceptual changes.

24 MR. SULLIVAN: The concept of moving ahead

1 with the university impact analysis stays the same.

2 MS. PAVLE: One of my questions is if we want
3 to keep this just to the academic community. I'm just
4 thinking about public policy think tanks. We can think
5 outside of Illinois as well. Just throwing that out.

6 MR. DART: The reason that we're working with
7 the higher education is because we're allowed to contract
8 with those agencies directly without --

9 MS. PAVLE: Okay. My apologies.

10 MR. DART: You mentioned out of state. That's
11 something we didn't really discuss, but I don't think there
12 is a prohibition against an out-of-state university.

13 CHAIRMAN WAXMAN: My gut is, I wouldn't want
14 to go out of state. I mean, I --

15 MR. SULLIVAN: There's good expertise in
16 Illinois.

17 CHAIRMAN WAXMAN: I would think so, and it's
18 the state of Illinois that we're impacting. So, I would
19 say we don't want to go outside the state of Illinois.

20 MR. URSO: Mr. Chair, we just came up with a
21 title for this document, so we clearly all know what we're
22 talking about here, and we'd like to call it the Research
23 Invitation to Academic Institutions.

24 Does that fit in with your motion, Terry?

1 MR. SULLIVAN: Research Invitation to Academic
2 Institutions.

3 MR. URSO: RITAI.

4 CHAIRMAN WAXMAN: Does it have a good
5 acronym?

6 MR. URSO: Are you okay with that?

7 MR. SULLIVAN: We should move ahead with the
8 RITAI.

9 MS. CREDILLE: I second the motion.

10 CHAIRMAN WAXMAN: Do you have a question,
11 sir?

12 MR. WILL: A little wording question. This
13 may go to Staff, since you all wrote this, or whoever wrote
14 it. I was just thinking back on our previous discussions
15 and looking at some of the bullet points on residential
16 long-term care system communities. I'm assuming, based on
17 our previous discussion, when it says "long-term care
18 system," it will be clear to, you know, respondents, people
19 who do the work, that we're not just talking about things
20 that are licensed as nursing facilities; we're also talking
21 about home and community-based services, assisted living,
22 what have you. I think that's consistent with our -- I
23 don't know that that requires a change. I just want to
24 inquire as to whether that's still the intent.

1 CHAIRMAN WAXMAN: I think the -- I think I
2 agree. I think we can only ask them to review what we have
3 jurisdiction over, which is skilled nursing homes.

4 MR. WILL: My question is about -- if we're
5 thinking about doing this thing, it's not to make
6 recommendations that would be outside of our jurisdiction;
7 its to subserve the impact on the long-term care system,
8 given that these different settings are quite connected.

9 CHAIRMAN WAXMAN: Frank?

10 MR. URSO: I recognize your concern, and I
11 think if we can fold that into the analysis, why not have
12 them do that?

13 CHAIRMAN WAXMAN: Fine with me.

14 MR. URSO: This committee might not be able to
15 direct any policy recommendation or anything in terms of
16 those other entities that the Board doesn't have
17 jurisdiction over, but, still, we'll get a more
18 comprehensive impact analysis. That's just my thought.

19 CHAIRMAN WAXMAN: Again, my point was simply
20 that I have no problem having them do the research that is
21 broad in the whole continuity of care concept, but remember
22 that there are only certain parts of that that we can
23 impact.

24 MR. WILL: That's well taken. They should

1 know what we are able to do with the report when we get it
2 back.

3 CHAIRMAN WAXMAN: Mr. Sullivan?

4 MR. SULLIVAN: April, May, whatever the last
5 meeting that we had after Claire's research -- not the last
6 meeting we had, but after Claire's research, we had
7 developed almost like a bullet point decision tree of about
8 ten or so decisions that would make up what a bed
9 relocation program looks like: Moratorium, yes, no;
10 geographic area; time frame; stuff like that; and we
11 actually started discussing that. I think that those
12 bullet points, those decision points based on Claire's
13 research probably -- and I don't know if Bill will be in
14 charge of it -- probably should be part of the questions
15 that we're asking the institutions, to say we would like
16 your -- the impression of other states of geographic
17 impact, moratorium, bed reduction, stuff like that.

18 CHAIRMAN WAXMAN: I would agree. I guess --
19 do we want to -- I guess I have a procedural question, and
20 I don't know whether we should vote on the motion first and
21 then come back to the procedure, or continue to discuss.
22 Frank, what do you think?

23 MR. URSO: After you have the second, it's
24 open for discussion.

1 CHAIRMAN WAXMAN: So my question to Staff --
2 and I guess I'll point to Bill at the moment -- how will
3 this committee be involved in the selection of the
4 respondents, assuming there is more than one respondent to
5 the letter?

6 MR. DART: Well, in the latter part of the
7 letter, we talk about respondents being invited to discuss
8 the concept with the working group which was focused on
9 this. So, the working group then would recommend to the
10 full committee either one or multiple respondents for the
11 group to choose from. We have proposals submitted from one
12 or more, and they be reviewed and brought to this full
13 group.

14 CHAIRMAN WAXMAN: I just want to make sure
15 that we did not lose our ability to impact the study and
16 the selection process. So, in your concept that will not
17 happen?

18 MR. DART: No, that will not happen.

19 CHAIRMAN WAXMAN: Then I'll call for the
20 vote. All in favor of the motion?

21 ("Ayes" heard)

22 CHAIRMAN WAXMAN: Any opposed?

23 (No response)

24 CHAIRMAN WAXMAN: The silence is deafening

1 and shocking. Motion carries.

2 Okay. Moving on -- thank you, all. It's
3 great to have this group agree and especially so many
4 people participating. So thank you very much.

5 Okay. Moving on to 9, Long-Term Care Reforms,
6 Change of Ownerships, Discontinuation and Addressing
7 Underutilized Long-Term Care Beds; and I guess my question
8 is -- Staff is starting this discussion, and which Staff is
9 starting this discussion?

10 MS. KENDRICK: I will begin. So, obviously,
11 we already had somewhat of a discussion on February 4th
12 about these ideas. We wanted to create some documents so
13 that the Subcommittee members could use something to base
14 how the Board came to their decisions and their solutions
15 to these two issues that they felt were problems or issues
16 that the Board should address, that happens to affect
17 long-term care.

18 CHAIRMAN WAXMAN: I'm sorry. Would you
19 distinguish the two issues, because it's one line on the
20 agenda.

21 MS. KENDRICK: So we see the first issue is
22 requiring the change of ownership and discontinuations of
23 long-term care facilities to come before the Board; and the
24 second issue is to address the over bedding issue in the

1 state of Illinois. So, we kind of organized those as
2 legislative initiative number one and initiative number
3 two. So, hopefully everybody was able to read through the
4 documents. I know there was a number of attachments to the
5 invitation.

6 So, I mean, really what we would like to see
7 during our discussion today is feedback, and, I would say,
8 as opposed to just general opposition, maybe some
9 suggestions. And, you know, I apologize if maybe some of
10 this information wasn't presented well enough at the last
11 meeting, but we hope that maybe this provides a better
12 background and a basis for discussion.

13 So, I don't know if anybody wants to start off
14 with some general feedback or --

15 CHAIRMAN WAXMAN: We're going to concentrate
16 on the change of ownership and discontinuation question
17 first?

18 MS. KENDRICK: Right, we'll start with the
19 first initiative.

20 CHAIRMAN WAXMAN: Chuck has been champing at
21 the bit the last three hours.

22 MR. FOLEY: First of all, I want to thank
23 everybody for detailing the issue in the way it was
24 detailed. I think this is very, very helpful, whoever put

1 this together. I thought that they did a good job.

2 I guess my first comment -- and to stick with
3 the issue of change of ownership and discontinuation --
4 it's my understanding that since all of this was removed
5 from the Board's purview, there has, in fact, been
6 comments, complaints, whatever, from community folks out
7 there, and I guess back in my mind, the question in terms
8 of number of complaints. Number one, exactly what were
9 those complaints; and, number two, how many complaints are
10 we talking about in a month's time, to make it simplified?
11 So, is this an occurrence that happens all the time or just
12 once a year, once a month, whatever? I don't know.

13 And I guess my second comment on this would
14 be, at the last telephone conversation, obviously there was
15 a lot of opposition, and I think the opposition was
16 probably based on the fact of the way it was presented.
17 This obviously presents it in a more clear understanding as
18 to why the State is asking us to actually do this.

19 But I guess we have to be cognitive of how is
20 this going to really and truly help the industry? Are we
21 going to eliminate an existing step, or are we going to
22 create another bureaucratic step that the providers have to
23 go through? By that I mean, we talk about change of
24 ownership. Right now they just notify the Department of

1 Public Health and they have to -- I'm assuming they have to
2 go through the application process. And the question is,
3 if they now have to go through the CON, that will now
4 constitute yet another application. Is there any way that
5 the two could be combined, that we could work with
6 Licensure and combine these into one application, so that
7 when it's approved by the Board, it automatically goes to
8 Licensure? So, if an application could be, you know,
9 created in such a way that addresses the Board's concerns
10 and also the concerns of Licensure, if that's possible,
11 then I think that's what the industry would like to see.
12 That's my personal opinion, but I'll leave it for
13 discussion.

14 CHAIRMAN WAXMAN: Toni, from your perspective
15 do you have any thoughts on this subject?

16 MS. COLON: I'm sorry. You're suggesting
17 specifically what change or process?

18 MR. DART: I think Chuck is suggesting that
19 Licensure and Board Staff work together to minimize the
20 amount of duplication and make the process as efficient as
21 possible.

22 MS. COLON: I would definitely support that.
23 I know operationally within the section within our program
24 that processes these license applications, it's working

1 fine. I think the goal ultimately should be to reduce
2 redundancy and tasks.

3 I actually reviewed the history of the
4 challenges maybe four or five years ago that had taken
5 place, sat down and had an internal work group meeting with
6 my employees, and they suggested that it would create a
7 significant lag time if there were any changes to the
8 current system, potential lag times. So, I'm stating that
9 if the Board could take into consideration operationally
10 what we do within Program -- if you'd like something in
11 writing, step by step what the staff currently do, I'll be
12 glad to provide that and look at what is being recommended
13 and what potential additional job tasks that may develop.
14 I'd like for the committee to take that into consideration
15 as well.

16 CHAIRMAN WAXMAN: I think -- and, Bill,
17 correct me if I'm wrong. I think the issue is this -- the
18 Committee on the phone, the members who were on the phone
19 conference, the concern I heard is that it appears the
20 system is currently working and no one wants to make the
21 system more complicated, less efficient, and more time
22 consuming.

23 MS. COLON: Correct.

24 CHAIRMAN WAXMAN: I think that's what I

1 heard. So, if this proposal, for whatever reason is coming
2 forth, will make it more efficient and less time consuming,
3 I think the Committee would listen to it very favorably.
4 But I don't know that we've heard that yet. Have we heard
5 that yet, Mike?

6 MR. SCAVOTTO: No. So, I appreciate the
7 write-up. I'm still in the same position as I was on the
8 conference call. So, help me out. What is the problem?
9 How big is the problem? How deep is the problem? I don't
10 think I got that.

11 MR. CONSTANTINO: We get complaints, when a
12 facility closes, from the community. That's when we get
13 the calls to the staff at IDPH. They're telling us that
14 they did not know that the facility was closing.

15 MS. AVERY: Or change of ownership.

16 MR. CONSTANTINO: Or change of ownership.
17 This happened with my mother just here recently. I was
18 never notified, and I'm ten, fifteen minutes away from that
19 facility.

20 MR. SCAVOTTO: Okay. So there were 44
21 incidents what, last year?

22 MS. AVERY: For discontinuation?

23 MR. SCAVOTTO: 39 CHOWs and 5
24 discontinuations, and that was in calendar year 2012.

1 MR. CONSTANTINO: The one thing you have to
2 realize, Mike, the statute requires that we be notified,
3 and that's not being done. All of that information is
4 being given to us by IDPH.

5 MR. SCAVOTTO: And what I'm suggesting to you
6 is, that is really relevant information that we're not
7 getting and, you know, you need to tell us. That's why I'm
8 asking you those questions.

9 So, of the 44 that happened in 2012, how many
10 complaints were associated with that? It goes back to what
11 Charles is asking. What were the complaints? Where were
12 they? Realistically speaking, you're not going to do this
13 without -- with zero complaints. So, if there's -- what
14 I'd like to know is if it's just 3 or 4 out of 44? Half?
15 What's the scope of the problem?

16 MR. CONSTANTINO: We get calls, like I told
17 you, when a facility changes ownership and the community
18 does not know. That's when we get the calls. Now, there's
19 44 here. We could very well have had 44. I did not keep
20 track of them. I don't know. That's what I'm telling you.

21 MS. O'DEA EVANS: I think that whether or not
22 someone had the knowledge base to call the Department
23 doesn't mean that the community wasn't impacted or those
24 persons who were receiving the services weren't impacted.

1 So I think if there was a -- five discontinuations of
2 nursing homes, that is obviously going to impact all of
3 those individuals who were utilizing that facility as a
4 long-term care setting, and to think it's always going to
5 be a positive thing for them is probably not true. So, I
6 think we should know that it's likely had an impact that
7 may not have been positive for some of those people.

8 CHAIRMAN WAXMAN: Terry?

9 MR. SULLIVAN: The Nursing Home Care Act
10 requires a 90-day notification to the Department, to the
11 doctors, to the families, to the residents that the
12 process -- that there will be a discontinuation. All of
13 that is above board. I find it hard to believe that
14 somebody says, "Oh, a facility is closing and I didn't know
15 about it." I mean, that's just not true. When a facility
16 is closing, it is -- the State comes in, there's monitors
17 assigned, there's case workers involved in the change for
18 families.

19 Nobody wants to see a facility close, not
20 families, not residents. Unfortunately, given the current
21 reality of the State of Illinois, that does happen; but it
22 is a process and it's well monitored. I'm not aware that
23 any facility just up and went and said, "We're closing in
24 24 hours." That doesn't happen.

1 MR. CONSTANTINO: Terry, our statute requires
2 them to notify the Board, and they're not doing that.

3 CHAIRMAN WAXMAN: Notify which Board?

4 MR. CONSTANTINO: The CON Board. Those
5 notifications are not being received by the Board for
6 discontinuations or change of ownerships.

7 MS. JOHNSON: And I will see that the
8 ombudsmen definitely are being notified -- are not being
9 notified that facilities are being closed, until they go
10 into the facility and find out that it is closing.

11 CHAIRMAN WAXMAN: So now we've got two groups
12 that are not notified. Is it routinely you're not notified
13 or occasionally you're not notified or always not notified?

14 MR. CONSTANTINO: For the CON Board, we have
15 not received any notifications that these facilities have
16 closed.

17 CHAIRMAN WAXMAN: I'm sorry?

18 MR. CONSTANTINO: We have not received any
19 notifications that these facilities closed. That just
20 requires a letter, and that's not being done. What we're
21 proposing is that we be allowed -- this should be back into
22 the CON program so an opportunity for a public hearing can
23 be put in the paper and given an opportunity to comment on
24 these change of ownerships and discontinuation.

1 CHAIRMAN WAXMAN: Tim?

2 MR. PHILLIPPE: As a provider, I guess I want
3 to separate two issues. Okay? The first issue is the
4 notification of the community. The opportunity for a
5 public hearing and people to express concerns seems wise to
6 me personally, even as a provider, because this is a
7 regulated area, and so because the State -- in a sense, the
8 Board -- controls the number of beds in a community, it's
9 not market based. Then when ownership changes, it can have
10 a big impact on the community, and I think it's not like
11 it's market driven. It's controlled already, and so it
12 makes sense that there should be some opportunity for the
13 public to know about a change. It just seems rational.

14 The second issue is just time. A few years
15 ago, we took over a not-for-profit, and it was months and
16 months, and it created lots of problems that almost caused
17 the other organization great difficulty, because we just
18 couldn't get to the hearing. So, as long as it's timely
19 and doesn't drag the process out for many months and create
20 a problem, another type of problem, I think the process of
21 actually making it public and an opportunity for a hearing
22 makes good sense public policy wise. I don't think our
23 members would have an issue with that. People should know
24 when changes are occurring.

1 CHAIRMAN WAXMAN: You're representing --
2 Chuck, I'll come back to you. I know you had your hand up.
3 He raised the issues of his members.

4 MS. CREDILLE: The position of Illinois
5 Healthcare is that the current system is working and there
6 is notification through the Department, and as Terry has
7 already said, there's already 90-days notice. If it is
8 that a letter doesn't go to the CON Board, I don't know why
9 we can't do something simpler than opening up a whole CON
10 process for either change of ownership or closure of a
11 facility.

12 CHAIRMAN WAXMAN: Toni?

13 MS. COLON: I'd also like to add, I know our
14 program is definitely communicating to the Department of
15 Aging, as well as to the Health Facilities Review Board.
16 Internally we're disseminating information. I don't know
17 if the particular request is that the facility sends a
18 formal notification to the Department of Aging or not, but
19 I know internally we have communications. I just wanted to
20 put that out there to clarify.

21 MS. JOHNSON: Well, yeah, Public Health does
22 notify when you know. But we've had ombudsmen go in the
23 facility the day of their visit and find out that the
24 facility is being closed, and that's when they become

1 involved, to work with the residents, to see about choice.

2 So, I'm just saying everybody doesn't know. That's just a
3 fact. Everybody doesn't know.

4 MR. CONSTANTINO: That's been my experience.

5 MR. URSO: I just want to make sure everybody
6 understands that these are two separate statutory
7 requirements. One is with the Department of Public Health
8 for the 90-day notice; and the second one is a statutory
9 requirement of the Health Facilities and Services Review
10 Board, that they need to receive a written notification if
11 there is a change of ownership or discontinuation. The
12 Board is not seeing that. That's what Mike is saying, and
13 that is a statutory requirement.

14 MS. CREDILLE: Could you clarify? If you just
15 notify that there is a change of ownership or
16 discontinuation, that does not require any kind of review.
17 Notification is not analogous to review or oversight.

18 MR. FOLEY: I Was going to say, could
19 Licensure notify the Board that there is a change?

20 MR. URSO: The requirement of the statute is
21 that the institution that is closing or changing ownership
22 is supposed to notify the Board of that transaction.

23 MR. FOLEY: So, when a facility notifies
24 Licensure by letter that they're going to close, could that

1 letter just be turned around from Licensure and forwarded
2 directly to --

3 MR. URSO: That's how we're getting the
4 information now, but what I'm saying is, it is the
5 facility's responsibility to provide written notice to the
6 Board that they're closing or discontinuing.

7 MR. FOLEY: I understand that. What I'm
8 saying, one would have that notification through Licensure,
9 maybe not directly from a provider. You're still getting
10 it from a provider.

11 MR. SHEETS: Maybe you need some teeth to
12 enforce that.

13 CHAIRMAN WAXMAN: It sounds like an education
14 issue. The facilities need to be informed.

15 MR. CONSTANTINO: They would be informed if we
16 received notice and an opportunity for a public hearing.

17 MR. PHILLIPPE: Actually, I think we've got to
18 separate two issues, at least what I'm hearing people talk
19 about. One is when the Board gets notified and how that
20 happens; but I think the other issue some people are
21 talking about is, it has a community impact, rather than
22 just being notified and it's a done deal, it seems like,
23 because, like I say, it's controlled by the State through
24 the CON process. If I live in a community and a change of

1 ownership, do I not have a right to know that my only
2 access is to this one building and I have a right to find
3 out who is owning the building and their reputation before
4 they move into my community? Normally in business you
5 wouldn't think so, except this is controlled. They may be
6 the only facility in that community, and the company buying
7 it may already own the other facility in that community.

8 So, it seems to me like some process, as long
9 as it's timely, it doesn't drag out the process too long,
10 to let the community know through a normal process seems
11 like it makes sense to me.

12 MR. CONSTANTINO: All other healthcare
13 facilities as defined by our Act are required to come
14 before the Board and get approval for a change of ownership
15 and a discontinuation. We believe that the long-term care
16 facilities need to do the same thing. They should not be
17 excepted.

18 CHAIRMAN WAXMAN: I guess the question, Mike,
19 is whether or not you can have whatever you need to do in
20 the same 90-day period that they're notifying Licensure.
21 Otherwise, you're talking about 90 days notification of
22 Licensure and then X amount of time on top of that, and
23 you're lengthening the process, and that's the opposition,
24 what I'm hearing.

1 MR. CONSTANTINO: What we're proposing is an
2 exemption process, similar to what we did back prior to
3 September of 2006. There was no 90-day period to get those
4 exemptions approved. We didn't have a 90-day. Most
5 generally, those were approved within 30 to 45 days by the
6 Chair. We gave everyone an opportunity to call for a
7 public hearing, if they so desired.

8 CHAIRMAN WAXMAN: Alexis?

9 MS. KENDRICK: I just wanted to kind of -- you
10 know, I don't mean to be redundant, but this is very much
11 within the Board's existing purview. These are
12 transactions that the Board is charged to do. I mean, this
13 is not the Board exceeding its authority.

14 CHAIRMAN WAXMAN: You're talking about the
15 Mother Board?

16 MS. KENDRICK: The Mother Board. So, the
17 issue of people not complying with the statute and not
18 providing us notification, that's a separate issue that
19 maybe we can also address; but this is very much within the
20 Board's purview, and if the real issue -- which I wasn't
21 here in 2007 when the original bill was pushed, but it was
22 my understanding that the conversations weren't had
23 explaining what the complaints were, what was the issue
24 with change of ownerships happening at that time, so we

1 could have come to a compromise about the process; and I
2 think if we can come to a compromise about the process,
3 that would serve the benefits of the community, keep the
4 Board fulfilling its purpose, and avoiding any concerns
5 from the industry.

6 CHAIRMAN WAXMAN: Chuck?

7 MR. FOLEY: I could see, obviously, a need for
8 notification of the Board on a discontinuation. I guess if
9 there is a way that the Board and Licensure could work this
10 out -- I think what Mike said, prior to, the timeline on
11 this was less than 30 days and usually no more than 45
12 days, back in the old days. It did go by very quickly.
13 The Board did not receive that many requests for a public
14 hearing. Once in a great, great while they did receive a
15 request for a public hearing, and that was maybe something
16 like -- I'm just trying to think of one that was really on
17 the radar screen. I think of Oak Forest Hospital, maybe
18 which would have had an impact, et cetera, et cetera. But
19 by and large, I don't think the notification process was
20 really that much of a problem. So, I think if there is a
21 way between the Board and Licensure that they could work
22 out the process to ensure that everything gets done in a
23 timely manner so that it goes to the Chair, and if the
24 application that is submitted is looked at and reviewed and

1 the Chair could approve it without going to the full Board,
2 that application, in turn, goes directly to Licensure, and
3 that's also Licensure's notification maybe for the 90 days
4 also. I don't know. That's something the two would have
5 to work out; but at least we're using the same application.

6 I don't know how long it takes now to go
7 through, for instance, a change of ownership. I'm
8 switching between discontinuation and change. I don't know
9 how long it takes to go through a change of ownership. I
10 can't see it taking that long through Licensure, and so I
11 can't see it taking that long either through the Planning
12 Board also to work with Licensure. So, I think there might
13 be room -- I agree with what everybody is saying. I know
14 where Cece is coming from, where Tim is coming from. I've
15 talked to several providers out there. All I get is, "No,
16 no. It's just another bureaucratic step we have to go
17 through that's going to cost us money, because now it's
18 going to be an application fee involved." I don't know how
19 much the application fee is involved for Licensure versus
20 how much it would cost to go before the Planning Board;
21 but, again, I'm sure that's something that could be worked
22 out, that it would be one and the same.

23 CHAIRMAN WAXMAN: Terry?

24 MR. SULLIVAN: We have a process that I think

1 is working fairly well right now when it comes to change of
2 ownership and discontinuation. Public Health is doing a
3 good job of notifying the ombudsmen and the Health
4 Facilities Planning Board. I call that efficiency. It's
5 one agency, one letter, and, yes, Frank, you're right. I
6 know the statute says long-term care facilities, if they
7 discontinue, are supposed to send a letter to the Board. I
8 guess, you know, every agency would like to be -- to have
9 their statute followed. I guess I'm raising the question
10 of relevance. If a facility is closing, it's a traumatic
11 experience all around for families, for residents, for
12 staff. Notifying Public Health is something that we're
13 very aware of, because it's the regulatory agency, and
14 there are federal and state statutes. But, in worrying
15 about getting staff other jobs, in worrying about placement
16 of residents in other facilities, in working with families,
17 there's a lot going on in discontinuing the facility, and,
18 yes, I can see facilities not remembering that they are
19 supposed to notify the Health Facilities Planning Board,
20 since they are working so closely with Public Health. It
21 is something that does get overlooked and lost. I'll
22 apologize on behalf of the people I know. But -- and I
23 think a lot of providers would say, "What's the relevance
24 of writing a letter to the Board? Public Health knows

1 about it and Public Health informs you. Do we really need
2 this letter to inform you?"

3 CHAIRMAN WAXMAN: I'm hearing that, one, it's
4 the law.

5 MR. SULLIVAN: It's the law.

6 CHAIRMAN WAXMAN: And, two, it's the only way
7 for the community to have public access to a public
8 hearing. I'm hearing that's the issue, because there is no
9 public hearing option under Licensure.

10 Toni, correct?

11 MS. COLON: Correct.

12 CHAIRMAN WAXMAN: So, I'm hearing that's the
13 issue. So that's the two issues I hear. It's that pure
14 and simple. The law says the CON Board needs to be
15 notified. The other issue is that, you know, if we
16 acknowledge the community has a right to a public hearing,
17 that's the only way it can happen.

18 The opposition is, we don't want to add any
19 more time to the process. So, the question now is, can the
20 two organizations work in such a way that they can get a
21 public hearing option out there and their notification out
22 there with not extending the length of time? I think
23 that's the issue. Correct? Am I missing something,
24 Mr. Sheets?

1 MR. SHEETS: There's just so much here to talk
2 about, I don't want to waste everybody's time with a half
3 hour of the history of this whole issue.

4 CHAIRMAN WAXMAN: You'll take some of
5 Mr. Foley's time. It's okay.

6 MR. SHEETS: But I will say this: The
7 facilities that close -- I think there's a misconception.
8 Most of the facilities that have closed over the past year
9 were closed down by the government, by the State or by the
10 federal government. So, the option of notifying the Board
11 and getting permission to close, when you're being closed
12 down by the State, doesn't really make sense. It's not a
13 practical problem, I don't think, on Mike's part. If
14 they're going to close, it's usually they're either going
15 bankrupt or somebody is closing them, and in Illinois, it's
16 usually somebody is closing them. So, we have that issue.
17 It's not really a real problem, in my opinion. Nobody just
18 decides they're going to close down their nursing home. It
19 just doesn't happen. It's an asset. It's worth money.
20 Nobody wants to close it down.

21 But on the change of ownership side, I think
22 we have to look at what's happened with the Board in the
23 past and why the industry is somewhat reluctant to go
24 forward with this; and let's take an example. I mean, the

1 statute is clear with other healthcare facilities. Section
2 8.5 -- Frank brought it up before -- Certificate of
3 Exemption for Change of Ownership of a Healthcare Facility.
4 That section is supposed to address changes of ownership
5 for healthcare facilities. If we look at the Board's
6 agenda, the Mother Board, it has a whole new meaning now.
7 The mother Board's agenda -- not the hard drive's agenda --
8 (Laughter)

9 MR. SHEETS: So, the Mother Board's agenda, as
10 probably -- like, look at dialysis, for example. Half of
11 the dialysis projects that are on the Board's agenda right
12 now are changes of ownership, full CON applications,
13 because even though there's this provision in the statute
14 that says Certificate of Exemption for Change of Ownership,
15 you know, the Board over the years has found a way to
16 develop some standards to qualify for this that make it
17 impossible for certain industries to qualify, and that's
18 what happened with long-term care. They couldn't get a
19 Triple A bond rating, because they're all private
20 companies, small business owners. So, they all got dragged
21 through the CON process, and then it took six months, four
22 or five months to do a change of ownership, up to a year.
23 So that's why this happened. Now we're hearing, "Well,
24 we're going to handle this differently." I think the

1 industry is a little leery of that.

2 Be that as it may, the only real issue that
3 I've heard brought up -- that I agree with -- is the public
4 hearing, and that's on a change of ownership issue only.
5 On the closing, there's a federal requirement. The
6 administrator of a long-term care facility has to notify
7 the ombudsman, the federal government, all of the
8 attendings within 90 days of a closure, or there's a
9 \$50,000 fine that can go to that personal administrator.
10 So, there's all kind of regulations on closure already and,
11 again, it's usually the government doing the closing, and
12 they're out there helping and assisting the residents to
13 find a new place to go, and they're working with the
14 ombudsman. So that's not a real issue, in my opinion,
15 based on my experience.

16 MR. OURTH: Joe Ourth. In listening to this,
17 it would be interesting if there was a large group of
18 surgery center people industry around. I think you'd
19 probably hear them saying, "You know, we've got a real
20 problem on this. We ought to expedite this and have an
21 easier process for change of ownership." And if we had
22 hospital people around, they would probably say much of the
23 same thing.

24 If the Planning Board has a policy thing, and

1 if there is a policy function for change of owner and
2 discontinuation -- and maybe there, and maybe there
3 isn't -- what I would suggest -- and I work with a number
4 of these -- is that we try to find a global solution on
5 that; if the issue is timing, that there be something that
6 expedites that and works with that with hospitals. But I
7 don't really see a big policy distinction between long-term
8 care and surgery centers and categories of care for
9 hospitals.

10 So, to the Mother Board, I would say, if
11 you're trying to find a solution, try to find a global
12 solution to it that applies to all of the industries that
13 you regulate and not just the single one.

14 CHAIRMAN WAXMAN: There's logic to what you
15 said. Unfortunately, as a friend of mine keeps saying,
16 we're living in an illogical world. But our ability to
17 make recommendations is solely limited to long-term care.
18 So even though what you've said makes a total amount of
19 sense that we do this once and do it for everybody, we
20 can't do that.

21 Right, Frank?

22 MR. URSO: (nods)

23 MR. OURTH: That was directed to Mike and that
24 side of the room.

1 CHAIRMAN WAXMAN: Mr. Sullivan?

2 MR. SULLIVAN: Just a little history. The
3 reason that we have this subcommittee, which was
4 established in legislation, was that, based on the hearings
5 that the Health Facilities -- that the Legislature had, one
6 of the strong things that came out was long-term care
7 facilities are not hospitals, and for too long, the
8 regulations were being broad-stroked across the Board,
9 applying to everybody, and a lot of them inappropriate for
10 long-term care. And so, one of the reasons in the statute
11 that we have this committee is that it's not the same
12 business plan; it's not the same model. It is one thing
13 for a hospital to be closing in a community, and that has
14 significant impact and they don't have the same licensure
15 process that we have. They're primarily accredited; and so
16 closing a hospital, they need to go through something like
17 the Planning Board.

18 I am not sure that closing a nursing home --
19 since we already have federal and state requirements for
20 notifying Public Health and Public Health gets very
21 involved very quickly, this becomes a duplicative step.
22 We're not adding beds to the system. We're not bringing in
23 a new facility. We are putting beds back in to the system,
24 and that's a paperwork exercise that the facility should do

1 but Public Health does, and I think that's a very efficient
2 approach.

3 MS. KENDRICK: Mr. Sheets, you said that one
4 concern was back before 2006, the number of the exemption
5 applications would then turn into CON applications and that
6 stretches out the process and the time. I mean, would you
7 suggest to the Long-Term Care Subcommittee that the bond
8 rating requirement should no longer apply to long-term care
9 facilities, that there is a justifiable reason why that
10 shouldn't happen for long-term care facilities?

11 MR. SHEETS: Absolutely, but, you know -- I
12 don't think --

13 MS. KENDRICK: Long-term care has their own
14 regulations. It's all 1125, and this committee is
15 responsible for developing the regulations for what would
16 potentially be a change of ownership application.

17 MR. SHEETS: I don't know what the agenda of
18 this subcommittee is, but I think there are a lot of things
19 that could be written or revised that would obviously help
20 long-term care -- help the Mother Board evaluate long-term
21 care applications better. But I don't see changes of
22 ownership as being a top priority.

23 Another thing that Mr. Sullivan was talking
24 about is, changes of ownership happen all the time in

1 long-term care. I mean, there's always 40 or 50 a year
2 that are going on, and the question becomes, you know, why
3 does the Board want to know about these so bad? Is there
4 an issue? Do they want to say no? Because we know that
5 the Department of Public Health evaluates the operator and
6 that there are strict rules on who can run a nursing home.
7 So, it becomes an issue, I think, of Public Health
8 notification only.

9 CHAIRMAN WAXMAN: The question that you
10 raised about our purview is that we can make
11 recommendations about any part of long-term care. As Terry
12 said, one of our major initiatives is to make sure we are
13 distinguishing between hospital regs and long-term care
14 regs. So the proposal is an option. If getting rid of
15 Triple A rating solves some of the questions, that's
16 something we can put on the table. So, I guess -- did you
17 want to go down that road or not?

18 MR. SHEETS: No.

19 MR. SULLIVAN: Isn't Mike's committee handling
20 some of that, or at least leading up to that?

21 CHAIRMAN WAXMAN: Mike?

22 MR. SCAVOTTO: It's come up, yeah. It's not
23 going to come up today.

24 I would like to go back to Alexis, and I don't

1 want to misstate, so correct my recollection. I thought in
2 your remarks you indicated that this proposal doesn't
3 really expand the current authority that you have.

4 MS. KENDRICK: Correct.

5 MR. SCAVOTTO: So, I'm slow on some of this
6 stuff. So, if it doesn't expand your current authority,
7 that says to me that you've got the authority already. How
8 come we're not using it? Is that a fair question?

9 MS. KENDRICK: It got excepted out. So that's
10 basically what happened in 2007, was the bill was pushed
11 forward to say that the authority that the Board has to
12 look over change of ownerships and discontinuations will no
13 longer apply.

14 MR. SCAVOTTO: So we don't have the authority?

15 MS. KENDRICK: We don't have the statutory
16 authority, but it's not beyond the Board's other purposes
17 and Act and requirements to do these type of evaluations.

18 MR. CONSTANTINO: It's just for long-term
19 care, Mike. It was only excepted for long-term care, no
20 other healthcare facility.

21 MS. KENDRICK: And that was not the decision
22 of the Board to do that.

23 MR. SCAVOTTO: I'm just trying to get
24 background on this. So, we don't have the authority to

1 require this now?

2 MS. KENDRICK: No, because it's their specific
3 language, saying that it should not apply.

4 MR. SCAVOTTO: So help me out on these
5 proposed changes of two bullet points. How do those two
6 bullet points help out?

7 MS. KENDRICK: So, those two paragraphs
8 include language that says that the Act should not apply
9 for change of ownership for nursing homes and should not
10 apply to discontinuations of nursing homes.

11 MR. SCAVOTTO: So it reverses the exception?

12 MS. KENDRICK: Right. So the language was
13 added to exclude. So we would then remove the language so
14 that they're no longer excluded.

15 MR. SCAVOTTO: Thank you.

16 MR. URSO: Can I just piggyback a little bit
17 on this --

18 CHAIRMAN WAXMAN: Sure.

19 MR. URSO: -- and respond to something Terry
20 said a few minutes ago? The legislation was changed back
21 in 2006, 2007 to exclude nursing homes from the Board's
22 jurisdiction for discontinuations and change of ownerships.
23 What was put in place that the Board also didn't have any
24 say in is there would now -- it would now require a written

1 notification if there was a change of ownership or
2 discontinuation. So, it is very relevant, because this is
3 back -- what the proponents of this bill back in 2006 to
4 2007 put in place of the Board's jurisdiction and authority
5 over these change of ownerships and discontinuations. So,
6 it is very relevant, and the only reason that is in there
7 now is because whoever put forth this bill put that in and
8 essentially replaced the Board's authority over change of
9 ownerships and discontinuations with this written
10 notification. And all we're saying and Staff is saying
11 that that is not being complied with. So, it's very
12 relevant.

13 CHAIRMAN WAXMAN: Yes, sir.

14 MR. FLORINA: I understand the notification
15 requirements and, apparently, the statute is there and it's
16 not being followed. The question I have is, if there is a
17 public hearing process that's allowed, is the expectation
18 to change the outcome of the change of ownership or the
19 discontinuation of a facility by having that? If there is
20 no expected change in the outcome, then why are we doing
21 it?

22 CHAIRMAN WAXMAN: That's a Staff question.

23 MS. KENDRICK: We can't expect or predict how
24 the Board would vote. I mean, that's up to our nine-member

1 independent board.

2 MR. CONSTANTINO: Public hearings are very
3 important for us. They provide us with information the
4 Staff cannot collect, and it provides us with another
5 avenue where we review -- where we can view what these
6 facilities are doing and not doing. I know when I look at
7 a public hearing, read the public hearing transcripts, I
8 find a lot of information that is helpful when I go and
9 review the CON applications. It provides a very useful
10 tool to the Staff.

11 CHAIRMAN WAXMAN: Mike, I think the question
12 is -- and, again, I may be wrong. The question is, even if
13 there is a public hearing, the decision to not close a
14 facility is not going to be reversed, is it?

15 MR. CONSTANTINO: The public hearing would
16 have to come first. The public hearing would be held
17 before the facility could be discontinued.

18 MS. CREDILLE: If there's a facility that's in
19 trouble, whether it's financially or regulatory, to have a
20 public hearing where the Board might say, "We're not going
21 to let you close", meanwhile they're hemorrhaging; they're
22 hemorrhaging either on a regulatory side or the financial
23 side. Maybe there's some other issue, but those would be
24 the two that come to mind. I don't understand the purpose

1 of a public hearing for the discontinuation, because if the
2 Board said you can't close -- really? I can't pay my
3 bills, I can't turn on the lights, I can't take care of the
4 patients.

5 MR. CONSTANTINO: I'll give you a very good
6 example. Oak Forest Hospital.

7 MR. SCAVOTTO: That's a good example.

8 MR. CONSTANTINO: It is. The Board would not
9 let them discontinue, because the community wanted to have
10 assurances that that facility would do what they were
11 telling the community they would do.

12 MR. SHEETS: It's a government institution.

13 MR. CONSTANTINO: I understand that, but those
14 public hearings provide very useful information to the
15 Staff. Right now the only thing we look at for long-term
16 care is establishments. That's all we look at. The
17 thresholds are so high that we never see any modernization.
18 You come in and add a few beds, even though the facility is
19 not at 90 percent. So, all we do now is look at
20 establishments. Yet, for every other healthcare facility,
21 we regulate the discontinuations and change of ownership as
22 part of our purview. We want to go back to what we had in
23 place prior to 2006. We think it's an important part of
24 our statute.

1 CHAIRMAN WAXMAN: Mike, can you --
2 "guarantee" may be too strong of a word, but can you assure
3 the Committee that you would -- not you personally, but by
4 allowing the Board to have that reversed, that you wouldn't
5 extend the length of time to make a decision that is
6 currently in the 90-day range? I mean, that's --

7 MR. CONSTANTINO: I have reviewed all of these
8 exemptions for change of ownership for long-term care for
9 three or four years for the CON program, when long-term
10 care was part of the exemption process. I cannot recall
11 any that took 90 days. I cannot recall any change of
12 ownership that took 90 days, unless they could not provide
13 us with the documentation that was required.

14 CHAIRMAN WAXMAN: Toni, from your perspective,
15 is there an issue with what they're proposing? Is it an
16 additional burden?

17 MS. COLON: As far as their request for a
18 public hearing with the process, I just -- we're talking a
19 lot about voluntary closures, but I think we're also
20 missing the component of involuntary closures. From a
21 regulatory perspective, we revoke licenses and won't allow
22 a facility to renew and/or operate and go through the
23 decertification process. I know I'm bringing up another
24 variable, but how would that component work? Because it

1 does affect what you're looking into. I think that it's
2 definitely doable to have Public Health provide
3 notification that is sent to us from facilities, directly
4 to the Facilities Review Board, so they can post their
5 public hearing notice. I think that the 90-day period is
6 ample time for notification and hearing and a review. I
7 think that it's an important component. So, I think we can
8 work out logistically how we can make that happen within a
9 reasonable time period.

10 MR. CONSTANTINO: We did it in the past, Toni.

11 MS. COLON: I don't see that being an issue.

12 MR. CONSTANTINO: I don't either.

13 CHAIRMAN WAXMAN: So, my question then to
14 Mr. Sheets or to Terry: Does your "no" vote disappear if
15 there is assurance that what the Mother Board wants to do
16 does not add time to the process? Or are there other
17 issues that you are opposed to?

18 MR. SULLIVAN: My "no" vote doesn't disappear.
19 And on the public service side, I am sure that the
20 Associations can get notice out to all its members,
21 reminding them that under the law, they do need to notify
22 the Health Facility Planning Board, and the Associations
23 have neglected to do that. But now that it's an important
24 issue, we will make sure that most members conscientiously

1 comply with the current requirements.

2 MR. SHEETS: If I had a "no" vote, it would
3 still be "no". But let me just say this: I certainly can
4 understand Mike's expression. In those days, it did go
5 over without a hitch. Unfortunately, right now under the
6 rules -- I mentioned, like dialysis -- I don't think there
7 is anybody here -- maybe the exception of Tim -- whose
8 organization could pass the financial scrutiny of the Board
9 right now and get an exemption. For sure none of the State
10 organizations would, because they wouldn't qualify, based
11 on their credit ratings. So I guess what I'm saying is,
12 that even though Mike is sitting here saying he wants to go
13 back to that, I have no faith that everyone else would
14 agree with him and that the Mother Board would make those
15 decisions and end up in that same spot. I fear it would
16 end up in the same spot it is with other providers, as Joe
17 alluded to earlier.

18 MR. FOLEY: There is one thing we have in
19 place today that we did not have in place back in '06 or
20 '07, and that is this Subcommittee. So, in the future --
21 because a lot of the complaints I heard is what issues are
22 we going to have down the road five years from now where
23 Mr. Waxman is no longer the Chairman and Frank is no longer
24 legal counsel and we have a whole new team here and

1 everything starts over again, like it did in '06 and '07.
2 We had a subcommittee in place. So, if the information is
3 passed on to people who are following you, to give us
4 assurance why we did this and that's why -- I mean, we do
5 have transcripts. That basically protects everybody.

6 MR. SHEETS: They don't have any authority.
7 It just is a recommendation. They're going to do what
8 they're going to do.

9 CHAIRMAN WAXMAN: Alexis?

10 MS. KENDRICK: Right. I think the whole point
11 of the Subcommittee is to make those recommendations. If
12 you feel that the financial standards aren't possible for
13 the long-term care community, then make a suggestion of
14 what those standards should be and how the Board should
15 evaluate that. There is no dialysis subcommittee to hold
16 the Board accountable or make recommendations to the Board,
17 and I think the Board would be open to these
18 recommendations.

19 MR. CONSTANTINO: It would take a rule change
20 in 1130.520. It would take a rule change. You would have
21 separate -- well, I shouldn't speak for the Board. But it
22 would take a rule change right now, and we have to have
23 separate rules in 1125.

24 MS. KENDRICK: I think what we hoped, by

1 having this discussion today -- that's what the concern is,
2 that those changes would then cause a lengthy period, and
3 maybe that should be a change that's recommended. Now,
4 obviously, you're not a committee member, but that's
5 something that other committee members would be open to
6 then. I don't see why they can't be proposed and
7 suggested.

8 MR. SULLIVAN: Mike, as a matter of fact, a
9 set of proposed 1125 rules were given to this committee,
10 what, three years ago?

11 CHAIRMAN WAXMAN: When the joint
12 organizations met?

13 MR. SULLIVAN: Right, and under pressure of
14 deadlines, it was basically, "Let's just keep the same
15 rules now and we can talk about it in the future." But
16 there is something on the table that would be a much more
17 streamlined approach to the 1125 rules.

18 MR. CONSTANTINO: We included your 1125
19 economic and feasibility, word for word. We didn't change
20 a thing.

21 CHAIRMAN WAXMAN: Three days ago there was a
22 motion on the table. We should probably go back to it.

23 MR. PHILLIPPE: No, there's not one.

24 CHAIRMAN WAXMAN: There is not a motion? I

1 guess we need a motion, unless the people want to discuss
2 it further. We seem to be going in circles.

3 Tim?

4 MR. PHILLIPPE: Can I ask to move towards a
5 middle ground? If there is a motion to support this
6 process as you've recommended, could it include a time
7 frame? Sometimes they're too short; sometimes they're too
8 long to be feasible; and if there could be some kind of
9 time frame that was put in the motion --

10 MR. CONSTANTINO: Tim, right now in our
11 exemption rules for change of ownership, we have to deem
12 the exemption complete in 30 days.

13 MR. PHILLIPPE: So that's not long.

14 MR. CONSTANTINO: No.

15 MR. PHILLIPPE: My experience --

16 MR. CONSTANTINO: It's not approved by the
17 Chairman, but generally, in the past, the way that process
18 worked, we'd have the notice out within a week. I'm
19 talking about a public notice, and then if no one called
20 for a public hearing, we'd send it to the Chairman for
21 approval.

22 MR. PHILLIPPE: I don't know this whole
23 process like you guys do, but I went through it once, and I
24 know that I was calling somebody -- maybe not in this room,

1 hopefully -- an attorney, every day, because we -- it was
2 going to cause -- it had to do with getting on the Board
3 agenda. We could not get on the Board agenda to get it
4 done, and it went on for months, and it was -- it almost
5 created lots of problems for us, and so I don't -- I don't
6 have any --

7 MR. SHEETS: So you didn't even qualify for
8 the exemption.

9 (Laughter)

10 MR. PHILLIPPE: No, no, no.

11 MR. SHEETS: I was wrong.

12 MR. PHILLIPPE: No. Triple B-minus won't get
13 you there.

14 I don't think it has to do with Staff work. I
15 think it has to do with how busy the Board was at that
16 point.

17 CHAIRMAN WAXMAN: I wonder if the
18 recommendation could be that there be some discussion
19 between Toni's group and IDPH, so that they can come back
20 to us and say, "We now have procedures in place."

21 MR. SCAVOTTO: I don't think we're ready on
22 this.

23 CHAIRMAN WAXMAN: Well, I would still like to
24 see some procedures.

1 MR. SCAVOTTO: Well, yeah, and then I think we
2 might be ready.

3 CHAIRMAN WAXMAN: So, rather than move it
4 forward -- and, again, as Chair, I hate to be doing this,
5 but I think what we would like to see is a discussion and a
6 work group between the organizations with something brought
7 back to us that says, "We've worked out procedures and
8 policies so that we can ensure communication and efficiency
9 and timeliness," and then this group would be more
10 favorably looking at that proposal.

11 Mike, is that kind of where you're at?

12 MR. SCAVOTTO: It would be very helpful.

13 CHAIRMAN WAXMAN: Terry, does that sit okay
14 with you?

15 MR. SULLIVAN: Sure.

16 CHAIRMAN WAXMAN: Cece?

17 MS. CREDILLE: Yes.

18 CHAIRMAN WAXMAN: Anybody else who has an
19 opinion on the subject? Otherwise I need somebody to --
20 other than you, Chuck.

21 MS. JOHNSON: May I, just for clarification?

22 CHAIRMAN WAXMAN: Please.

23 MS. JOHNSON: I didn't want to imply or want
24 anyone to think that Public Health doesn't notify

1 ombudsmen. We do get the change of ownership list. We do
2 get that, and when there are emergency closures, Public
3 Health does notify the ombudsman, and they go out there.
4 But I just wanted you to know that there have been some
5 instances -- and maybe they were an emergency closure due
6 to finances or late payments or whatever, but ombudsmen
7 have gone into facilities and residents are being shipped
8 out or moved to sister facilities, and I know there wasn't
9 a notice, there wasn't an opportunity for a public hearing,
10 and -- you know, so it does happen; it does happen, and I
11 just wanted you to know that it does.

12 CHAIRMAN WAXMAN: Thank you.

13 Chuck?

14 MR. FOLEY: I guess what I'm hearing is -- Tim
15 had mentioned earlier that he does, in fact, see the
16 relevance for a public hearing in terms of the change of
17 ownership, and I do agree with that, but then when you talk
18 about a public hearing for discontinuation, we see most
19 facilities are discontinued mainly because of the fact you
20 have no money, you can't continue to operate, or the State
21 is coming in and closing them down. I thought the earlier
22 process, that if you were being forced to close by a
23 governmental agency -- i.e., the State or the Feds -- there
24 was even a shorter process, that you didn't even have to go

1 through the exemptions. Is that correct, Mike?

2 MR. CONSTANTINO: I don't recall that.

3 MR. FOLEY: I thought there was something, if
4 the federal government came in and said you had to close, I
5 don't think an application was required, because you had to
6 close. So, I guess my question is, in terms of a
7 compromise, how important is it to have a public hearing
8 for a discontinuation versus a change of ownership? You
9 know, let's have an application process for a
10 discontinuation that they notify the Planning Board, and,
11 again, that same application goes to Licensure as part of
12 their 90-day notice, if that could be done, but a public
13 hearing would not be required.

14 Going back early, early on in the history of
15 the Board, one of the reasons why discontinuations really
16 came into place -- I do recall years back that there was a
17 provider down in southern Illinois, a nursing home
18 associated with a hospital, and to my recollection, the
19 hospital was kind of forcing this particular nursing home
20 to close, because they wanted to establish the service
21 themselves, and, obviously, that got everybody in a big
22 uproar and this big battle down there, and the Chairperson
23 at that time was a lady by the name of Pam Taylor, and she
24 got all upset over it. And then there was another instance

1 up here in the western suburbs, maybe Elgin or somewhere,
2 where a large AMI facility had closed maybe two or three
3 days before Christmas, and they notified Public Health and
4 said, "We're closing in two days; get all of your patients
5 out of here," and it was like wham. This hit everybody in
6 the face real hard, and the concern at that time was how
7 and where are these residents going to be placed, are they
8 appropriately placed? And a lot of the residents from up
9 here ended up being transferred to southern Illinois. So,
10 that did not provide for a thorough transition. So that
11 was a major concern. Hence, that was why all of this
12 discontinuation subject came up.

13 Yes, you know, the Board cannot stop somebody
14 from closing, technically speaking. If they're running out
15 of money, they don't have the funds to do it, you know,
16 they're going to close anyway. So, I guess if we're going
17 to compromise with something, we really need a public
18 hearing for a discontinuation as we do for a change of
19 ownership. I don't know. I'm just bringing that up for
20 discussion and trying to bring this to a closure.

21 CHAIRMAN WAXMAN: Chuck, maybe we can add
22 that to the assignment of Staff, when they come together to
23 come back with a document to us, that they can look at the
24 question that you have proposed or raised.

1 Staff, are you okay with looking at that
2 issue? So, again, what we're looking for -- and, again, I
3 hate to do this as Chair, so I hope somebody else will make
4 a motion. But looking for various State departments,
5 someone sitting at the table, to come back to us with
6 policies and procedures of how they can ensure the
7 communication and efficiency will be maintained, so that
8 the proposal will not extend in any way, shape, or form the
9 current practice and yet accomplish the needs that have
10 been raised. Also now, the question that Staff can look
11 at, can -- do we only need an application for change of
12 ownership and not for discontinuance? So, any agreement to
13 that concept? And if so, could somebody be so kind as to
14 make a motion for me?

15 MS. COLON: Motion.

16 CHAIRMAN WAXMAN: We have a motion from Toni.
17 Second?

18 MR. PHILLIPPE: Second.

19 CHAIRMAN WAXMAN: We have a motion and a
20 second.

21 Pat?

22 MS. O'DEA EVANS: I just think that, you know,
23 when we're looking at discontinuation of services, there
24 was five last year. It's not a high-volume number,

1 compared to the change of ownership. But I still think
2 it's important to have the opportunity for the Constituents
3 to voice their concerns in a public hearing, no matter what
4 the reason is, or to try to predict that they're all going
5 to be because of financial difficulties is, I think, a
6 little presumptuous of us. There could be many reasons,
7 and you can't really predict that. So I don't really want
8 to just throw it out of the equation.

9 CHAIRMAN WAXMAN: And the proposal is for
10 Staff to look at it seriously and see if they can come up
11 with enough reasons not to have it versus to have it. Your
12 point is, I think, part of the evidence that Staff needs to
13 look at.

14 Are you okay?

15 MS. O'DEA EVANS: (nods)

16 CHAIRMAN WAXMAN: Okay. So we have a motion.
17 The motion basically is that we're asking or requiring
18 various departments of the State of Illinois to come
19 together and bring back to our group a document that
20 supports that they can create efficiencies and policies and
21 procedures to incorporate the need of the CON Board to have
22 their needs met without adding any additional time to the
23 existing process, so that everybody is notified
24 appropriately and public hearings can be required or

1 scheduled within the same time frame that is currently
2 operating; as well as ask Staff to look at the question of
3 whether or not there needs to be two applications or two
4 criteria established for public hearings for
5 discontinuation and public hearing for CHOW's. That's the
6 motion, to direct Staff to come back to us. We have a
7 motion made by Toni and a second. All in favor?

8 ("Ayes" heard).

9 CHAIRMAN WAXMAN: Opposed?

10 (No response)

11 MR. SULLIVAN: Abstentions?

12 CHAIRMAN WAXMAN: If you want me to.
13 Abstentions, please?

14 (Pause)

15 CHAIRMAN WAXMAN: We have two.

16 And we do want a time frame put into that
17 motion.

18 Toni, are you okay with that?

19 MS. COLON: Sure.

20 CHAIRMAN WAXMAN: What works for you guys?
21 Staff, what's your time frame?

22 MS. KENDRICK: Do we have another Subcommittee
23 meeting scheduled?

24 MS. AVERY: Not yet.

1 (Discussion held off the record.)

2 CHAIRMAN WAXMAN: So you're proposing to have
3 this done by -- before -- so that it can go to the --
4 you're proposing you'll have this information back to this
5 Board prior to the Mother Board meeting on March 26th.

6 MS. CREDILLE: I'm sorry, because --

7 MS. AVERY: I was saying that we would
8 possibly have to remove it from this legislative session
9 because of the Staff. We will present it as a
10 recommendation from you all, not saying that it will be
11 okay with the Board, but we'll present it that instead of
12 introducing it as a legislative initiative for this
13 session, this is what you wanted us to do.

14 CHAIRMAN WAXMAN: Correct.

15 MS. AVERY: And that we won't get a response
16 from the Board until after the March 26th meeting.

17 CHAIRMAN WAXMAN: Okay.

18 MR. DART: I think we want to say when we're
19 going to have our follow-up on this assignment. So it
20 would probably be sometime after the March meeting?

21 CHAIRMAN WAXMAN: So we will have a
22 meeting -- our next meeting will be sometime in April.

23 MR. DART: Courtney, do you think April would
24 be feasible?

1 CHAIRMAN WAXMAN: Our next meeting is April,
2 so the question is, will you have this information in our
3 hands prior to our April meeting? Yes?

4 MS. AVERY: Yes.

5 CHAIRMAN WAXMAN: Is that agreeable with
6 everybody here.

7 Cece?

8 MS. CREDILLE: I'm not sure I heard everything
9 that was being said. So this will not be moved forward as
10 a legislative proposal, or the Board could make a decision
11 otherwise?

12 MS. AVERY: We're going to take this
13 recommendation to the Board, saying that instead of having
14 this legislative initiative for the change of ownership and
15 discontinuation, the Subcommittee would like for us to do
16 that and possibly look at it for a future initiative or
17 whatever the outcome is. That will be the recommendation
18 from this Board -- from this Subcommittee to the Board.

19 MS. CREDILLE: Okay.

20 CHAIRMAN WAXMAN: Cece, does that answer your
21 question?

22 MS. CREDILLE: Um-hum.

23 CHAIRMAN WAXMAN: So it will be our agenda
24 item in April. Are you still abstaining?

1 MS. CREDILLE: Yes.

2 CHAIRMAN WAXMAN: Terry?

3 MR. SULLIVAN: Um-hum.

4 CHAIRMAN WAXMAN: Okay. The motion passes.

5 It's about five to 12:00. We'll adjourn for a
6 few minutes. The Court Reporter needs a break. When you
7 see the Court Reporter back in the room, you know we are
8 ready to start.

9 (Recess)

10 CHAIRMAN WAXMAN: Can we come back to order,
11 please?

12 (Pause)

13 CHAIRMAN WAXMAN: What I'm trying to avoid is
14 getting into a topic and then have food arrive. So
15 before -- and food is supposed to be here in the next few
16 minutes.

17 So, can we pick the next meeting date, get
18 some agreement as to when we can do that? We need an April
19 date, and looking at the calendar in Courtney's hand -- we
20 have been using Tuesdays. This is the third Tuesday. So
21 the third Tuesday would be the 16th. How does that work
22 for people?

23 (Pause)

24 CHAIRMAN WAXMAN: I haven't heard any

1 objections to it yet.

2 (Discussion held off the record.)

3 CHAIRMAN WAXMAN: 23rd work?

4 (Pause)

5 CHAIRMAN WAXMAN: Anyone with a problem on
6 the 23rd?

7 (Pause)

8 CHAIRMAN WAXMAN: The 23rd; and one of the
9 key agenda items then will be the documents that Staff will
10 put together for us on the motion above.

11 That being said, does anyone have any "Other
12 Business" they want to put before the Committee before we
13 get into the second item of Number 9? Any additions to the
14 agenda before?

15 (Pause)

16 CHAIRMAN WAXMAN: Okay. We currently -- are
17 we currently with some open seats?

18 MS. AVERY: Yes, we are.

19 CHAIRMAN WAXMAN: How many open seats do we
20 have.

21 MS. AVERY: We have three open seats; and
22 feedback from individual Committee members is that they
23 felt like this Subcommittee is too large. In a brief
24 discussion with Frank, we would have to have a legislative

1 change -- I mean, a bylaws change to reduce it.

2 CHAIRMAN WAXMAN: Or we leave the seats open.

3 MS. AVERY: Or we leave it vacant. But if
4 there is someone that is dying to be on the Committee or
5 that we think will help with the work of the
6 Subcommittee -- we asked -- I think once we suggested
7 someone from academia.

8 CHAIRMAN WAXMAN: We've gone to two academia
9 people, and they've told us they're busy.

10 MS. AVERY: So, if it is someone that can
11 really contribute and the Committee feels strongly about
12 it, fine; but the feedback I received consistently is that
13 the Committee is too large for a Subcommittee.

14 MS. CREDILLE: To that end, when we changed --
15 Frank, you got to keep me honest on this. We changed term
16 limits, I'll call them. So now I'm going to say it's
17 August, but I don't remember when it is -- sometime in the
18 fall. We're drawing out of a hat or something, that some
19 of us will only be on the Committee for a year, and some
20 will be on two years. If you make the Committee smaller
21 and then some people are only on for a year -- I'm just
22 talking out loud here -- then we may run into difficulty
23 down the line. We changed that, is what I recall.

24 CHAIRMAN WAXMAN: What we've done is, we

1 changed so that people have terms, not the size of the
2 Committee. So, if your term is up and you choose not to be
3 reappointed, then we'll find somebody else.

4 MS. CREDILLE: But I thought you couldn't be
5 reappointed. Isn't there some language? Am I crazy?

6 CHAIRMAN WAXMAN: Got to wait a year. Sorry.
7 It's not to reduce the size. It's to get some rotation.
8 Again, if people want to volunteer for a one-year or a
9 two-year or a three-year term, then, of course, that saves
10 the picking method. So you need to think about that.

11 MS. AVERY: I think it's October, September or
12 October. I think it's October.

13 MR. URSO: It's staggered.

14 CHAIRMAN WAXMAN: Yes. That's the object.

15 Okay. Anything else?

16 (Pause)

17 CHAIRMAN WAXMAN: In that case, then do you
18 want to lay out the discussion for the second point of
19 your -- let's move forward with the Staff's position, if
20 you will, or definition or whatever.

21 MS. KENDRICK: So our second initiative is the
22 proposed initiative to address the over bedding situation
23 in the state of Illinois. So we would adjust the bed
24 inventories for nursing homes that have an annual average

1 occupancy of under 90 percent, so that all facilities are
2 operating at 90 percent. We would want to establish the
3 procedure and the due process for how we go about doing
4 that.

5 The other handouts that we included are some
6 data that Mike was able to pull for us. So, the one
7 document, Summary of Annual Occupancies for the Last 11
8 Years -- so as you can see, since 2000, the annual
9 occupancy has decreased from, I believe, 81 percent to 76
10 percent. Another illustration that we thought would be
11 helpful -- we just randomly picked an HSA. This was HSA 2,
12 and we saw how -- we illustrated how currently the Planning
13 Area is operating, how the bed-need formula calculates
14 where there is a need, and where there is an excess, and
15 each column to the right of the chart illustrates how the
16 bed-need formula would be impacted based on if beds were
17 removed, from 80 percent to 85 percent to 90 percent
18 occupancy.

19 So, we see this as a way to improve our
20 bed-need calculation, as a way of enforcing what our
21 existing Board standards are, and as a way of ensuring that
22 we have accurate and correct data for the Board to operate.

23 So, I know there is feedback for this, so I'm
24 not sure if anyone has any questions about any of the

1 numbers that were presented.

2 MR. SULLIVAN: Could you walk through the
3 example of impact, like Putnam, Bureau-Putnam, 326, 103,
4 346. What do those numbers mean?

5 MS. KENDRICK: So, right now the -- so the
6 number of licensed beds right now for Bureau-Putnam is 373.
7 So, if we were to adjust the inventory to 90 percent, that
8 would adjust the number of beds to 326 beds in the
9 Bureau-Putnam area, per county. So that would change the
10 bed need -- so right now the bed need comes to about 56
11 beds are needed in the area. That would change to then 103
12 beds would be needed in the area, and then every facility
13 would be operating at 90 percent.

14 MR. SULLIVAN: So just in HSA 2, going to the
15 bottom, if we went to 90 percent, we would increase the bed
16 need from 123 to 1,137?

17 MS. KENDRICK: Yes.

18 MR. SULLIVAN: Wow.

19 CHAIRMAN WAXMAN: Terry, say that again.

20 MR. SULLIVAN: At the very bottom, HSA 2,
21 right now the identified bed need is 123 beds are needed in
22 that area out of about 8,000 beds.

23 CHAIRMAN WAXMAN: Okay.

24 MR. SULLIVAN: If we go to 90 percent, the bed

1 need would go from 123 to 1,137 in HSA 2.

2 MR. CONSTANTINO: A couple things, Terry.

3 One, this is based on the 2000 census and was a 10-year
4 projection. The statute has been changed now to a 5-year
5 projection, which is a lot more reasonable, and then we'll
6 be using the 2010 census data. We believe our projections
7 were overstated, based upon the information we got for the
8 2010 census.

9 MR. SULLIVAN: Okay.

10 MR. CONSTANTINO: So we believe we overstated
11 it by about 3 or 4 percent on our population projections.

12 MR. SULLIVAN: Michael, so what I'm reading
13 here, in a state that has 15,000 empty beds already, based
14 on old data, we're suggesting taking away 10,000 of those
15 beds of the 15,000, I'm guessing.

16 MR. CONSTANTINO: Right now --

17 MR. SULLIVAN: If we went to 90 percent.

18 MR. CONSTANTINO: We're looking at probably
19 15,000 beds, 14,500 or 600.

20 MR. SULLIVAN: That we would take out?

21 MR. CONSTANTINO: Right, if we went to 90
22 percent.

23 MR. SULLIVAN: My past -- you're saying
24 there's more than 15,000 empty beds?

1 MR. CONSTANTINO: Yeah. I'm saying there's
2 22,000.

3 MR. SULLIVAN: 22,000 empty beds; so, we're
4 taking away 15,000 and adding how much more to the
5 inventory?

6 MR. CONSTANTINO: It would create a need in
7 some Planning Areas and some it won't.

8 MR. SULLIVAN: Correct, but if we went to 90
9 percent, we'd be adding --

10 MR. CONSTANTINO: We only did this for this
11 one --

12 MR. SULLIVAN: One county?

13 MR. CONSTANTINO: Right.

14 MR. SULLIVAN: So we don't know the global
15 impact of this kind of thing?

16 MR. CONSTANTINO: No.

17 MR. SULLIVAN: So we're taking away beds from
18 existing facilities, so we add more bed need into the
19 inventory. I'm missing something here. I'm flabbergasted.

20 MR. CONSTANTINO: The existing facilities are
21 not using the beds.

22 MR. SULLIVAN: So --

23 MR. CONSTANTINO: Don't you think we should
24 have an opportunity --

1 MR. SULLIVAN: So, take them away so other
2 people can build beds?

3 MR. CONSTANTINO: Why not? Maybe they can do
4 a better job.

5 MR. SULLIVAN: This is a discussion we had
6 three years ago, that the reason we have 22,000
7 empty beds -- that this Committee, this Board has nothing
8 to do with -- has been the incredible and advantageous
9 expansion of home and community-based services, of assisted
10 living, where seniors have other options other than nursing
11 homes and --

12 MR. CONSTANTINO: But that's been reflected in
13 our data, because the utilization, historic utilization,
14 has been going down almost close to 15 percent over the
15 last 12 years.

16 MR. SULLIVAN: But then you're saying take it
17 away from all of the people who have beds and open it up so
18 more people can build beds, when the future says we don't
19 need more nursing beds.

20 MR. CONSTANTINO: Terry, the facilities are
21 not using those beds.

22 MR. SULLIVAN: Because you can't fill them.

23 MR. CONSTANTINO: They're dead beds. They're
24 sitting there.

1 MR. SULLIVAN: Why are we increasing more
2 beds?

3 MR. CONSTANTINO: You're proposing to sell
4 beds in a market that's over bedded.

5 MR. SULLIVAN: Correct.

6 MR. CONSTANTINO: How does that work?

7 MR. SULLIVAN: It is the alternative to what
8 you're proposing.

9 MR. CONSTANTINO: For me that doesn't work
10 either.

11 MR. SULLIVAN: I think it is a good first
12 step, and we're asking to have an impact statement on what
13 bed relocation might mean in Illinois, and yet we're taking
14 a meat ax that both takes away 15,000 beds and then adds
15 more beds back into the system? I'm --

16 MR. CONSTANTINO: Terry, I'll give you an
17 example. I looked at one facility in Chicago. They're
18 operating at one and a half percent, 250-bed facility.
19 That's what they reported to us, one and a half percent
20 utilization.

21 MR. SULLIVAN: I don't know how they're in
22 business. That --

23 MR. CONSTANTINO: That's 2011 data, what they
24 reported to us.

1 MR. SULLIVAN: I understand that. That
2 administrator doesn't know what he's talking about. I'm
3 sorry. There's no such thing as a one and a half facility.

4 MR. CONSTANTINO: Why should that facility
5 remain open or why shouldn't we take beds away from that
6 facility, if that's what they're going to operate -- how
7 they're going to operate it?

8 MR. SULLIVAN: How large is this facility?

9 MR. CONSTANTINO: 250 beds.

10 MR. SULLIVAN: And so they have 10 people in
11 it?

12 MR. CONSTANTINO: That's what they reported to
13 us.

14 MR. SULLIVAN: Okay.

15 MR. FOLEY: Are they in the process of
16 closing? Is that why?

17 MR. CONSTANTINO: I have no idea. That was
18 based on 2011 data that they reported to us.

19 MR. SULLIVAN: That's a excellent example of
20 where I recommend a site visit; and I'm aware of a lot of
21 private facilities that, yes, have 100 beds in two bedrooms
22 and, yes, they have 60 people in the facility in private
23 rooms who are paying for private rooms. So, you're saying,
24 take those beds away and force that facility only to rely

1 on private-pay residents? I don't know. Again, we want --
2 on something as small as bed relocation, we want an impact
3 study, and yet, on this, the impact is incredible. This is
4 earth shattering. It's an earthquake.

5 MR. CONSTANTINO: Terry, every application
6 that goes before the Board, the applicants constantly tell
7 us there's over bedding in these areas, and we need to
8 address it in some fashion, and bed relocation to me does
9 not get that answer.

10 MR. SULLIVAN: It's step one. It's step one
11 as an alternative and --

12 MR. CONSTANTINO: You've got historical
13 utilization going down, and you want to have the beds
14 remain the same, the bed numbers remain the same? That
15 doesn't work.

16 MR. SULLIVAN: And I will -- I mean, before we
17 even get to bed reduction -- and I thought moratorium was a
18 controversial discussion that would send people up a tree,
19 although I'm in favor of moratorium in my point of view.
20 But, good lord, this is not moratorium. This is taking a
21 meat ax to the whole solution.

22 MR. CONSTANTINO: Terry, every applicant that
23 comes before the Board is telling us they're going to
24 operate at 90 percent, and they're not doing it.

1 MR. SULLIVAN: Correct.

2 MR. CONSTANTINO: They are not doing it.

3 MR. SULLIVAN: Then maybe we have a discussion
4 about moratorium.

5 MR. CONSTANTINO: And then the facilities are
6 on an average of 35 to 40 years old. What good would
7 moratorium be? Don't you think you have to replace the
8 stock, the capital stock of these facilities?

9 MS. CREDILLE: You could do a moratorium and
10 the option of buy/sell, which is a methodology for
11 redistribution of beds, because then it infuses capital
12 into the facility. If you do a combination of moratorium
13 plus buy/sell, it would work.

14 MR. SULLIVAN: That's the Ohio model, the
15 Missouri model.

16 MR. CONSTANTINO: But this is Illinois. It's
17 a different state.

18 MR. SULLIVAN: I have nothing to say to that
19 argument.

20 MR. CONSTANTINO: A different state with
21 different rules. Did they have an over bedded issue? I
22 don't know. Do they have an over bedding issue?

23 MR. SULLIVAN: I think that's why they
24 established the moratorium, and then -- because there was

1 the issue of what about replacing, what about having a new
2 facility when there is a moratorium? Well, if you can take
3 from the existing number of beds, you don't break the
4 moratorium. That's where buy/sell/relocation came from,
5 and that was the safety valve in the system that allowed
6 new facilities and allowed capital infusion into older
7 facilities.

8 MR. CONSTANTINO: So the moratorium was part
9 of the bed sell?

10 MR. SULLIVAN: In those two states; not in
11 every state, but in those two states, and that was one of
12 the decision points that we all had to make, although
13 moratorium is also a controversial issue. We've just upped
14 the controversy in this discussion.

15 CHAIRMAN WAXMAN: Would one of you, for
16 purposes of consistency, define "moratorium"?

17 MR. SULLIVAN: That there is no expansion of
18 beds in the system whatsoever; in other words, no new
19 facility, unless you get beds within the existing system.

20 MR. FOLEY: Just back up a second, if you can.
21 It seems like the issue that is written on paper is the
22 fact that we have a lot of empty beds in the state of
23 Illinois, and we've heard numerous times why we've got
24 empty beds. We've got empty beds because a lot of

1 facilities -- well, primarily one of the reasons is, a lot
2 of the beds are not even there physically. A lot of beds
3 have been converted to unused, be it converting a three to
4 four-bedroom into a private or two beds less for whatever
5 reason. There's all kind of reasons out there.

6 I think we need to not just arbitrarily go in
7 there and start cutting beds. I don't think that's the
8 issue, and I agree with where Terry is coming from, but I
9 do think -- on this particular issue, I think we can -- in
10 fact, should, in fact, come up with a viable alternative,
11 which nothing has been discussed other than the fact of
12 "Let's cut beds," and I don't think that's what we really
13 want to do. We want to identify those dead beds and get
14 rid of them. But a facility could have empty beds for
15 other reasons that have not been brought up.

16 As Mr. Florina indicated to me just a little
17 while ago, there are facilities out there that are emptying
18 a wing for whatever reason or because they're going through
19 major modernization. So we need to reflect that somehow,
20 and that's what -- that could be reflected in the inventory
21 by looking and see if there is a spike in their occupancy
22 rate either up or down, obviously. But at a given point in
23 time, that facility does have a lot of empty beds.

24 So I think we need to be cognizant of that,

1 obviously, and there's other reasons also out there of why
2 a facility would have low occupancy rates. A lot of times,
3 I think, as Mike had already alluded, it's the fact that
4 this is a 50-year old facility; it has not been upgraded,
5 you know, in so many years, and people just don't want to
6 go there. There are a lot of -- and they're still
7 utilizing maybe three and four-bed wards. People just
8 don't want to go there. You have an 85-year-old person
9 that not only has to share a room with one other person but
10 maybe has to share a bathroom with three other people,
11 because we have a lot of facilities out there where
12 bathrooms are between two bedrooms.

13 MR. PHILLIPPE: Hey now. You're getting
14 personal.

15 (Laughter)

16 MR. FOLEY: My mother-in-law is in such a
17 facility.

18 MR. PHILLIPPE: Might be mine.

19 MR. FOLEY: In Springfield. I won't
20 mention it's out on West Washington Street. I won't
21 mention that.

22 I think we have to be cognizant of all of this
23 and see where we have the empty beds and look at them on an
24 individual basis and not just arbitrarily go in there and

1 get rid of beds for whatever reason. I'm not saying this
2 is right, but let's look for volunteers. Would anybody
3 actually be willing to give up any of their, quote, dead
4 beds? We've been hearing arguments that they're paying a
5 dollar and a half a day taxes on a bed and they're empty.
6 Why does a person pay a dollar and a half per bed on a bed
7 that's not even set up but yet they're paying for it?

8 CHAIRMAN WAXMAN: We've already talked about
9 it could be the basis of their financing. It's based on
10 licensed beds.

11 MR. FOLEY: And we heard that argument in
12 terms of financing.

13 CHAIRMAN WAXMAN: These numbers are based on
14 licensed beds? Is that the status?

15 MR. CONSTANTINO: Yes.

16 MR. SULLIVAN: And I think this is also a
17 discussion we had a year ago, and I think the summary of
18 beds by patient day is also an excellent example, and even
19 though this year, 2011, was the worst year, 87 percent of
20 the beds were used during peak bed time. It's an ebb and
21 flow profession that we have, and up until this year, 91
22 percent was the standard that all beds -- at some point,
23 facilities were 91 percent occupied sometime during the
24 year. Now is that every occupancy? No. We all ebb and

1 flow. Winter is a higher occupancy area; summer is less,
2 for all sorts of reasons.

3 But you take facilities and put them at 90
4 percent, you will be having people being turned away at
5 various times of the year, and I think that is something
6 that needs to be part of this discussion, that, yes, every
7 facility has 80 percent of their beds used at some point
8 during the year, maybe not every day, but at some point
9 they use them, and up until last year, it was 91 percent
10 pretty consistently, that all of your beds are filled at 91
11 percent at some time during the year. You need those beds.

12 CHAIRMAN WAXMAN: I'd like to give Karen a
13 chance to eat. So can we eat and let Karen have her lunch,
14 and then we'll come back?

15 MR. SULLIVAN: All in favor?

16 (Laughter)

17 (Recess)

18 CHAIRMAN WAXMAN: We'll return to our
19 meeting.

20 Let's pick up our discussion, in which we were
21 interrogating Mike about his numbers.

22 Mike, thank you for putting the numbers
23 together. You are responsible for that. We do appreciate
24 it. I guess we're trying as a group to understand the

1 impact of what is being suggested. It certainly is a very
2 dramatic impact to the industry to look at. So, again,
3 your numbers are based upon licensed beds, which means that
4 people are paying the bed tax on them. The current bed
5 taxes are what, a dollar and a half?

6 MS. KENDRICK: A dollar fifty per bed, per
7 licensed beds.

8 CHAIRMAN WAXMAN: The question then becomes,
9 why would someone pay a dollar and a half per day on a bed
10 that's empty or not even in existence? And one of the
11 answers is, or one of the key reasons, as I understand it,
12 is a lot of long-term care financing is based on licensed
13 beds, because it's linked directly to the generation of
14 revenue. There may be other reasons, but I think that's
15 probably key. So, the impact of taking licensed beds away
16 from a nursing home not only impacts licensed beds or beds
17 available, but you could have ramifications into the
18 finance world, where mortgage lenders will now find that
19 the security is much less than it used to be. I think we
20 have to kind of keep that in the back of our mind also.

21 Outside of that, you know, it's back to
22 discussion purposes. I think we kind of summarized where
23 we left off before Karen wanted to eat lunch.

24 (Laughter)

1 CHAIRMAN WAXMAN: Tim?

2 MR. PHILLIPPE: Could I just make a couple
3 observations? I think Terry's was a wise observation.
4 Just because the average is not there doesn't mean it's not
5 used during the year. So, more would be used during the
6 year than the average, which makes great sense.

7 But a couple things: One is, when we talk
8 about Certificate of Need, it's like we're dealing with a
9 commodity like gasoline and it's all the same. It's not
10 all the same. It has a ramification on census and also
11 change in the market, because, like you say, if it's a
12 50-year-old building that hasn't been kept up, maybe people
13 don't want to come there -- which is always interesting to
14 me, that they can find an option, by the way.

15 But the other point is, the payor is not
16 always the same. Gasoline is sold pretty much at the same
17 price. It's a commodity. But the problem is, the people
18 who are paying to be in those beds are not paying the same
19 amount. It varies dramatically, really, from Medicare,
20 private pay, Medicaid, insurance with payors; and that
21 affects really what happens, to a great extent, and so,
22 within the state of Illinois, we may have -- there may be a
23 lack of access in some communities for people on Medicaid
24 to a bed, even though there are providers in that community

1 who downsized from two to one, but it may be also they just
2 have a fixed amount of Medicaid that are certified beds in
3 their building and they won't take more. So, even though
4 the beds are out of use, people need the beds; they decided
5 the pay is too low to be able to afford to provide the
6 care, and that makes us different than Ohio, because we
7 operate in Ohio -- at least right now I am managing two
8 there -- and we're in process of expanding, where they have
9 the bed buying and selling.

10 And so, it's a very different market when the
11 Medicaid rate is much higher. It has less of an impact on
12 the decisions. So in the state of Illinois -- I'm just
13 trying to be practical -- if beds -- people don't build new
14 buildings in the state of Illinois so they can fill them up
15 with Medicaid people. It's a sad state; it's a sad
16 picture; but I think it's true, because they can't afford
17 to operate. If they do it, they just can't afford to build
18 the building and operate.

19 CHAIRMAN WAXMAN: Just for people who are not
20 as involved as some of us on a daily basis, the average
21 Medicaid rate is about what, one sixty?

22 MR. SULLIVAN: One thirty.

23 MR. PHILLIPPE: And that's only because of
24 Chicago pulling the rate up because of the variation in

1 Chicago due to historical issues. It's down close to a
2 hundred.

3 MS. CREDILLE: We're 49th out of 56, the last
4 data that I saw in terms of being the lowest.

5 CHAIRMAN WAXMAN: I thought we were 50th.

6 MR. SHEETS: No, we went back up.

7 MS. CREDILLE: We climbed up.

8 (Laughter)

9 CHAIRMAN WAXMAN: So, one thirty -- we'll use
10 Terry's figure. The average Medicare rate, would you say,
11 is like between three and three hundred fifty?

12 MR. SULLIVAN: Three fifty.

13 CHAIRMAN WAXMAN: So, if those of you who are
14 questioning why somebody does not go actively looking for
15 Medicaid residents, therein lies the answer; because,
16 obviously, as someone said to me once, you don't feed the
17 Medicare steak and the Medicaid hamburger. The cost of
18 housing is both the same. You basically have the same
19 lights, same utilities, same food. So therein lies some of
20 the issue of Medicaid not being always available to certain
21 areas.

22 MR. PHILLIPPE: I think that what some
23 providers appear to think is that when somebody new comes
24 and builds in a community -- it's the competitive issue.

1 You know, I think we have to be honest about it, really.

2 Some people don't give up their beds because they think
3 somebody will come and build across the street from them.

4 MR. SCAVOTTO: That's true.

5 MR. PHILLIPPE: It's just part of life. It's
6 just market pressure, and the difficulty that people worry
7 about is that the new people, they will not build to take
8 care of those Medicaid people; they will only build to take
9 care of the small fraction -- it's well under 50 percent --
10 that's made up of private pay and Medicare in the state,
11 and that hurts all of the other providers around them,
12 because they have less revenue with the same operation.
13 So, it's a practical issue.

14 But I'm on the other side, by the way, on the
15 bed need issue, because it's difficult when you have a need
16 somewhere -- you think there's a need -- and then people
17 aren't using your beds, and then you're going to the Board,
18 trying to explain why it's not 90 percent everywhere. So,
19 I think we also have a consumer issue of people do not have
20 access to services they need.

21 CHAIRMAN WAXMAN: Terry?

22 MR. SULLIVAN: We've talked a lot of times in
23 the Subcommittee about how the old long-term care world is
24 radically changing over the next five years, and it's

1 already taking place with assisted living and home
2 healthcare and community-based services, which are all
3 welcome. It expands the continuum. The other major factor
4 which is going to be happening right now is the whole
5 Medicaid managed care program, which things are going to be
6 negotiated based on volume or whatever, and, you know, a
7 90-percent facility may not want to deal with the managed
8 care company because they don't have to. They're happy
9 with Medicare. A 70-percent facility may, in fact, go with
10 volume and agree to take on the managed care client. So we
11 have no idea what's going to be happening in the next year
12 or two in terms of where and how beds are going to be used
13 based on the whole managed care initiative that's coming
14 through. Certainly now is not the time to be making major
15 changes.

16 MR. PHILLIPPE: I would disagree with one
17 thing. I think we do know, because I've never heard of
18 managed care going into a new market or industry without
19 reducing the number of people in institutional care. It's
20 a hospital, it's everywhere. They always push people down
21 to lower levels of care, right or wrong. I'm not taking a
22 side, but it's always happened, because that's just what
23 they do.

24 MR. SULLIVAN: I'm coming back in on that

1 argument, if I may. Illinois has one of the highest
2 hospitalization rates and rehospitalization rates in the
3 country. The managed care companies that are coming into
4 Illinois are very interested in Illinois, because they see
5 saving money on hospitalization rates by having them go
6 into long-term care. So, certainly in the near term, they
7 see us as an incredible savings, a 90-percent savings on
8 people being in hospital and being rehospitalized. So,
9 this is going to be an exciting, new time.

10 CHAIRMAN WAXMAN: Are their operating rates
11 any different than the current Medicaid rates?

12 MR. SULLIVAN: Depends on the client.

13 MR. SHEETS: Not at the moment, but the plan
14 is for it to be different.

15 CHAIRMAN WAXMAN: Higher or lower?

16 MR. SHEETS: Negotiated.

17 CHAIRMAN WAXMAN: Building by building?

18 MR. SHEETS: Provider by provider, yeah.

19 MR. FOLEY: A lot of it will be a negotiated
20 rate.

21 MR. SHEETS: But right now it's locked in.

22 MS. JOHNSON: And don't forget about the
23 transition of the Colbert, Liggetts (phonetic) and Williams
24 class members. That's going to be a huge volume of

1 residents going into the community.

2 CHAIRMAN WAXMAN: Out of nursing homes?

3 MS. JOHNSON: Yes, sir.

4 CHAIRMAN WAXMAN: But there really aren't any
5 community -- there really aren't anywhere near enough
6 community opportunities for the people who -- to equal the
7 number of people in nursing homes, though, right?

8 MS. JOHNSON: Well, resources are slim. It
9 depends on what part of the state-you're talking about,
10 too. And there's an issue with the mentally ill. There's
11 very limited resources, housing for the mentally ill.

12 CHAIRMAN WAXMAN: Where is the State in terms
13 of SLF's? Are they now looking at more applications?

14 MR. FOLEY: Still frozen yet.

15 CHAIRMAN WAXMAN: Okay. Mike?

16 MR. SCAVOTTO: What Tim is talking about, in
17 my experience all too true, and I know, Chuck, you were in
18 a meeting with me awhile back, last year I believe, and we
19 heard from one of the health plans, and the direction
20 was essentially -- I'll overstate it, but you get the
21 idea -- move ICF out of nursing homes; we're not going to
22 be able to do all of it. But that does tell us what
23 direction they're going to go. In my experience they will
24 do that. Now they can only do it if their network is built

1 up. So, if there's no SLF's for them to use or there's no
2 home care and community-based services to use, people get
3 clogged up in the system. But it brings into question
4 whether or not the 90 percent utilization of beds is worth
5 dying for right now, when we don't know what's going to
6 happen, and to me, this is a very complicated issue. We're
7 not going to solve it today. I think that what you're
8 dealing with at a Staff level is very much appreciated by a
9 lot of us, but this is a huge one, and I got to show my
10 thanks here. I think -- I don't know about the financing,
11 whether or not licensed beds counts towards financing. All
12 of my experience says it's whatever your cash flow is.
13 You've got strong cash flow; strong net income. That's the
14 issue much more so than the number of beds.

15 But whether it is or whether it isn't, if
16 someone is going to argue for licensed beds -- and that's a
17 Waterloo phenomena -- we've got to find a -- if you want to
18 have a bed and it's not costing the State anything, let
19 them have a bed. It's not going to hurt us any,
20 particularly if we're facing the fact of having ICF
21 decimated and sent downstream, not immediately but over
22 time. So, what is the percentage? Nobody knows at this
23 point. To me, this is really a complex, strategic issue,
24 and there's too many constituencies that have a very big

1 paddle in the water. We're never going to get this right.

2 The best we can hope to do is limit the damage.

3 MS. O'DEA EVANS: I think there's some very
4 valid comments being made here, because right now, with the
5 whole influx of the managed Medicaid population, I don't
6 even know how many beds are -- how many providers are even
7 contracting with Aetna Better Health and Illini Care. I
8 don't even know how many beds are available for those
9 constituents right now. I don't even know if we have that
10 number, and the only promise is not about the rate; it's to
11 get paid faster. That's the promise.

12 MR. PHILLIPPE: That would be true.

13 MS. O'DEA EVANS: And is that enough for a
14 facility to buy into the program? We have facilities that
15 might say, "You know what? I don't even want to get
16 involved with the managed care product." And we're going
17 to have no control over this. So these people may not even
18 have a place to go for rehab. So, if we say to a provider,
19 "Well, you haven't been using these beds," it might be
20 that's the provider that might be incentivized to contract
21 with a managed care provider, and we don't really know that
22 right now. I would love to know that. I would love to
23 know that when all of these managed cares are in place and
24 mandated that the patients will have a place to go if they

1 need care, because right now, I'm not sure that that's all
2 been taken care of.

3 MR. SCAVOTTO: It seems to me the issue is
4 still if -- we have pretty good insight into what a managed
5 environment is going to look like. You have to sit back
6 and ask yourself the question: What good is a bed-need
7 formula? The MCO is going to take care of it for you.

8 MS. O'DEA EVANS: Another factor in the
9 reduction of the utilization has also been -- CMS has been
10 putting more pressure on hospitals to keep people in
11 observation status. So, they're not meeting the three
12 midnight requirement anymore, and I think that's impacted
13 our numbers. If we look at 2012, I think that has had an
14 impact on these statistics for these organizations, and
15 we're not sure with that, is there going to be some
16 movement toward looking at that problem for --

17 MR. SCAVOTTO: There has been legislation.
18 It's a packaged Medicare days, not total days.

19 MS. O'DEA EVANS: Yeah. I mean somebody --
20 they're not really determining whether the person needed to
21 rehab. It's based on an arbitrary, three-day limit that
22 was set by Lyndon Johnson. You know, I mean, really.

23 (Laughter)

24 MR. SULLIVAN: Oh, no.

1 MS. O'DEA EVANS: So, we have -- no, but this
2 is starting to trickle into legislative action, because
3 people are upset about it, and we don't look at the patient
4 and say, "Does this patient need rehab?" We say, "Were
5 they in the hospital an arbitrary three days?" We don't
6 say, "Do they really need help physically?"

7 MR. SULLIVAN: Back when the average hospital
8 stay, what, was ten days?

9 MS. O'DEA EVANS: It was actually like 8.9.

10 MR. SULLIVAN: I'll defer.

11 MS. O'DEA EVANS: But we have to realize that
12 this is a time of extreme unknown variables with both of
13 these things going on.

14 CHAIRMAN WAXMAN: I don't think anyone can
15 disagree. I mean, I really don't. And some of the
16 comments were actually more than I had even thought about.
17 So, I appreciate people sharing their thought processes.
18 Some of the stuff -- some stuff I knew. Some of the stuff
19 I hadn't thought about, so thank you all for doing that.

20 I don't mean to shut the conversation down,
21 but, Tim, in your other role in the world, have you thought
22 about whether you will negotiate for a managed care
23 contract, or would you rather not answer that question?

24 MR. PHILLIPPE: No, I will, I will answer it;

1 and I will tell you -- because, really, I was in managed
2 care for 13 years, good and bad, with one of the big
3 national companies, and I saw changes across states, and I
4 saw sometimes it was bad, when it was brought into a state
5 without careful thought. People used to say, "We're not
6 going to be like TennCare," Tennessee's; that was just
7 chaos. Usually when managed care is on board, if you're
8 not on board, you're eventually left out. That's what I've
9 seen before. If you're eventually not a part of it,
10 there's no place for you anymore.

11 I remember meeting with famous places, Minear
12 Health Clinic, top mental health in the country, you know,
13 Topeka, and they don't exist anymore. They said, "We're
14 better than this; we're going to be different." And, good
15 or bad, you can't fight them. That's been my experience,
16 at least.

17 MS. O'DEA EVANS: We're still looking, though,
18 at managed Medicaid.

19 MR. PHILLIPPE: Right.

20 MS. O'DEA EVANS: And it's not something that
21 is attractive to a large number of homes. I mean, some
22 places have a large Medicaid population already. Of
23 course, they're going to be --

24 MR. PHILLIPPE: We do.

1 MS. O'DEA EVANS: -- inclined to be on board.
2 But the ones that are marginal in the Medicaid mix, they're
3 not necessarily going to be on board.

4 MR. PHILLIPPE: No.

5 MS. O'DEA EVANS: And so we're going to lose
6 those providers that dabble in the Medicaid population.
7 That's just my prediction.

8 CHAIRMAN WAXMAN: Tim, just so I understand
9 and maybe other people are asking the same question. You
10 have like 18 homes. So would your managed care rate be the
11 same in all 18 homes, or would it still vary by geographic
12 area?

13 MR. PHILLIPPE: We'll have to see. I don't --
14 it varies by region, like the rates set based on the cost
15 and the history of the building and all of that stuff. So,
16 we will have to see if we have -- we're not -- some of the
17 big companies have more leverage.

18 MR. SHEETS: He may negotiate in Chicago only
19 and not in southern Illinois. It all depends who is big in
20 that region and who the sources are.

21 MR. SULLIVAN: For the dual eligibles, there's
22 going to be eight managed care companies, in addition to
23 Aetna and Illini Care. So, we're talking about ten
24 different companies. Some facilities may be dealing with

1 five or six of them.

2 CHAIRMAN WAXMAN: And how do people become
3 part of the managed care? Are they State-assigned or do
4 they volunteer to join?

5 MR. SULLIVAN: You're generally offered to
6 join a particular network.

7 CHAIRMAN WAXMAN: It's a massive market by a
8 managed care --

9 MS. O'DEA EVANS: You either select one, or if
10 you don't select one by a certain date, then you're put
11 into one.

12 MR. SULLIVAN: For the client.

13 MS. O'DEA EVANS: Right.

14 MR. SULLIVAN: For the provider, you can
15 choose how many you want to sign up for, or none at all, or
16 whatever. But there is always the chance of just being
17 left behind as the train leaves the station. I mean, one
18 of the things we've talked about in this Committee a lot is
19 client choice. I mean, toss that out the window. I mean,
20 managed care companies are going to be determining where
21 somebody goes, regardless of whether they want to go there
22 or not. They can always say no, but then you don't get
23 coverage.

24 CHAIRMAN WAXMAN: Cece.

1 MS. CREDILLE: Just from my other life, we
2 entered into some contractual arrangements on the
3 demonstration project, and we were unable to fulfill the
4 contract, because there were no providers in the community
5 that would contract. So, we contracted and said "Yes,
6 we're in," but they -- there were no home health agencies
7 that would contract so we could discharge them. There were
8 no doctors that would follow. There were no labs. It was
9 endless. So at the end of the day, I couldn't take the
10 patients, because the ancillary services weren't there, and
11 it's really because of Illinois' reimbursement structure.
12 At the end of the day, managed care is coming in here and
13 every other state to save money. When we're at 49 or 50
14 already, the thought of saving money is pretty entertaining
15 to me, because we're already at the bottom.

16 But back to the point at hand, we really don't
17 know how this is going to impact the long-term care
18 industry, regardless of the setting, whether it's a SLF or
19 an SNF or a post-acute. We don't know, and the variables
20 in Illinois are very different than the other states,
21 because of our reimbursement.

22 MS. O'DEA EVANS: There's not a lot to play
23 with.

24 MS. CREDILLE: There's nothing to play with.

1 MR. PHILLIPPE: Actually, they will add costs,
2 because one thing we all know -- we all work with managed
3 care already through Medicare or other kinds of programs,
4 and what we find is, the paperwork, the appeal process is
5 much more onerous and expensive than it is with -- Medicaid
6 is efficient comparatively, and so it will take more time
7 and trouble.

8 MS. O'DEA EVANS: Yes, absolutely.

9 MS. CREDILLE: But that's all a side bar to
10 what the issue at hand is, taking 14,000 beds out of --

11 MR. FOLEY: Well, it is and it isn't.

12 CHAIRMAN WAXMAN: So, your intent was to have
13 this Committee do what? What is it you --

14 MS. KENDRICK: We would like a recommendation
15 regarding how to address the over bedding issue in
16 Illinois, and hopefully you can see that -- yes, I
17 understand, I would say, the general sentiment of the
18 Subcommittee. This is a very drastic solution we've come
19 up with, but the solution is based on our standards and
20 it's based on how we handled previous issues of wrong bed
21 inventory, how we handled it with the hospitals in 2009.
22 So, I mean, I'm hearing that there's obviously a number of
23 issues that would, you know, change what that solution
24 would be: The future impact of managed care; whether there

1 would be an impact on finances; whether, you know, creating
2 a new bed need is what we want in the state. So, I mean, I
3 would say what's a compromise? What's another
4 recommendation? Because this is what we hear when
5 applicants come to the table, that bed inventory is wrong,
6 and I don't think the Board wants to encourage providers
7 practicing what Tim was kind of describing, that you're
8 holding on to these beds so that other providers can't come
9 in. That's not something the Board -- that's not the
10 purpose of the Board. The Board wants to identify where
11 there is a need and where there are areas where there needs
12 to be care.

13 CHAIRMAN WAXMAN: Your question or your
14 comment?

15 MR. WILL: I would -- I was thinking when I
16 was looking at this, preparing for this meeting, about the
17 relationship between this specific proposal and the over
18 bedding issue, which is that it does -- it's kind of where
19 we started the conversation: Put some beds out and say
20 that there is a need for them and they're not there. And I
21 was wondering -- I was looking at stuff that we did, you
22 know, two years ago or so, when the Committee was starting,
23 and our major priorities and our top priority was fixing
24 the bed-need formula, which we haven't worked on; and our

1 ideas then ranged from throw it out to figure out a way to
2 do it that integrates the whole long-term care spectrum,
3 that takes into account home, community-based services,
4 assisted living and whatnot, and, you know, it seems to me
5 that the numbers you present make a real case for redoing
6 that, quite possibly, you know, ratcheting it downward,
7 and, you know, I was wondering -- like, you know, it would
8 be good to look at something that fixes the dead beds in
9 relation to the bed-need formula, you know, and if you were
10 going at this scale, I think you would have to.

11 MS. KENDRICK: Right. I think we've heard
12 that there could be very good reasons why a facility is
13 under utilized. Right? There could be very legitimate
14 reasons why the Board would not be in opposition. But
15 there could also be reasons that are not public policy.
16 Why should a facility hold on to beds that they're not
17 providing to the community that another provider could be
18 providing to the community?

19 CHAIRMAN WAXMAN: Chuck?

20 MR. FOLEY: Maybe a workable discussion,
21 alternative, whatever, would be something to the effect of
22 instead of arbitrarily taking away these beds -- and we
23 talked about this a long time ago, and that was to look at
24 the possibility of banking beds, so that instead of

1 arbitrarily taking away from a facility -- there are
2 problems with this. I'll be the first one to admit it, but
3 just for discussion purposes, if you have a hundred-bed
4 facility and sitting there with 80 percent occupancy, if
5 the Board wants to take away 10 beds, instead of taking
6 away those 10 beds in the inventory, just create another
7 column. Call it whatever you want, dead beds or whatever.
8 And now those beds are identified in this column, and they
9 can also be used for buy/sell, because now we know that
10 this facility potentially has this number of beds under the
11 buy/sell program.

12 So, you know, again, I'm sure there are faults
13 with this and I'm sure there are a lot of things that need
14 to be discussed and worked out, but I think it is something
15 that maybe we can look at, talk about. Evidently the first
16 alternative suggested earlier in the day was to go through
17 the volunteer method first, see how many facilities would
18 voluntarily give up beds. I don't think you'll find too
19 many that will; but, nevertheless, if you wrote a letter
20 and explained what you're doing and why you're doing it,
21 maybe you might get a couple, two hundred, three beds which
22 is better than nothing.

23 CHAIRMAN WAXMAN: Pat?

24 MS. O'DEA EVANS: Right now, the empty beds

1 represent about \$12 million of revenue to the State.

2 MR. SULLIVAN: From the bed tax, yes.

3 MS. O'DEA EVANS: So are we going to ask
4 permission for taking away -- no, just kidding.

5 MR. SULLIVAN: Taking away 15,000 would be
6 70.5 million, plus the match.

7 MS. O'DEA EVANS: But the match is coming from
8 the federal government.

9 MR. SULLIVAN: Um-hum.

10 MS. O'DEA EVANS: So we're getting paid --

11 MR. SULLIVAN: -- dollar for dollar.

12 MS. O'DEA EVANS: Why don't we raise the cost
13 of the beds, get more money in to the State that way?

14 MR. PHILLIPPE: Bed tax?

15 MS. O'DEA EVANS: No. They're already not
16 getting paid enough for these patients.

17 So, you know, I think, though, part of it is
18 per operator. It's probably not a financial disincentive
19 enough to not hang on to that bed.

20 MR. PHILLIPPE: That's true.

21 MS. O'DEA EVANS: And that's part of why
22 they're holding on to them, because there's always that
23 opportunity or that hope that maybe they will use this bed
24 or this bed will be helpful to them either when they sell

1 their facility down the road, or they may have a change in
2 condition where they're going to use that bed.

3 MR. FOLEY: When you bank these beds, they
4 could be banked, but they're still licensed as far as a
5 lending institution is concerned, but we do have 10 beds
6 that we could put in reserve, and, you know, I guess in
7 terms of discussion, he could always put those beds back in
8 operation, if he needs, at a certain point in time, just by
9 notifying the State Board. You know, so, yeah, I guess
10 there's ways that it could be --

11 MS. KENDRICK: I was going to say,
12 HFS currently -- we have shared these topics with them, and
13 they don't have any objection to these topics -- to both
14 the change of ownership and this idea. So, in terms of
15 making sure that other State agencies are not opposed to
16 this -- well, I won't say they can't take a position
17 because it's not a bill right now, but the idea, they
18 didn't have any objections.

19 CHAIRMAN WAXMAN: Tim?

20 MR. PHILLIPPE: It seems to me, if I try to
21 think about both sides of this, on the one side, people
22 would say it's not very good policy, because how do you
23 plan and make decisions based on all of these unused beds
24 when things are not being used, and so if you take them

1 away from us and the -- the providers, that opens up the
2 market for new providers or current providers to add new
3 buildings or expand their current buildings. I think
4 that's -- it seems on the other side to be wise public
5 policy based on what is really used.

6 On the other side, I think, for providers,
7 because we've been talking about bed buying and selling for
8 the last three years, a long time -- I've been involved for
9 three or four years and a lot of other people before that.
10 We are a poorly-funded state in our field. There are
11 providers who have been hoping that they could use some of
12 those resources some day, hopefully to fix up their
13 buildings and provide better care, maybe for other reasons,
14 but -- so, do you know what I mean? Once we start talking
15 about bed buying and selling and we've had these
16 discussions, when you come and say, "We're going to take
17 them away," people will say, "What? I thought I was going
18 to get money for these so I can do stuff." I can see both
19 sides of it. I think we can all -- it's a tough state.

20 CHAIRMAN WAXMAN: Mike?

21 MR. SCAVOTTO: So, it's a real tough position.
22 Do you have the legal authority to confiscate beds?

23 MS. KENDRICK: I would not call it
24 "confiscating" beds.

1 MR. SULLIVAN: You wouldn't.

2 MR. SCAVOTTO: Or whatever you want to call
3 it. Do you have the legal authority to do what you want to
4 do?

5 MS. KENDRICK: Well, we consider it under
6 collecting the State inventory, but that's why we want to
7 do it -- we want a legislative change for this to make sure
8 that that is clear, but it has been done by the Board in
9 the past for other --

10 MR. SCAVOTTO: I can see someone saying that
11 "I applied for the beds; you gave them to me and they're
12 licensed to me. They're not licensed to you. They're
13 now -- they're my property or whoever's property. What
14 right do you have to come in and take them?"

15 MS. O'DEA EVANS: Because there was a
16 condition --

17 MS. AVERY: But all of the providers in their
18 presentation and other attestation to the Board is saying
19 that we will be at utilization of 90 percent within three
20 years, and that has not happened.

21 MR. SCAVOTTO: And I get that, and I don't
22 think we will see 90 percent again for a long time.

23 MS. CREDILLE: In our CON application
24 discussion, we had that discussion. It's in the CON

1 application that says you have to operate at 90 percent.

2 We have suggested that perhaps that's not a reasonable
3 requirement.

4 MR. SCAVOTTO: The only way you're going to
5 meet 90 percent, if utilization keeps coming down, is to
6 grab some more, grab some more, grab some more. It
7 becomes --

8 MS. AVERY: Grab some more beds?

9 MR. SCAVOTTO: Yeah. Pretty soon we're all on
10 this --

11 MS. AVERY: The research, based on what Claire
12 has done -- we thought that was relatively high, 90
13 percent.

14 MR. FOLEY: It's very high.

15 MS. AVERY: But it's consistent with other
16 states.

17 CHAIRMAN WAXMAN: I think what is clear,
18 unless I'm not seeing it as clearly as I think I'm seeing
19 it, is that there is a lot of apprehension among certain
20 members of this Committee to move forward with this
21 proposal as stated, because of so much unknown and so much
22 change in the environment, that I think we, as a group --
23 and, again, I hate doing this as the Chairman, but I think
24 there's consensus that the group is not in favor of

1 proposing that legislation. Am I right?

2 MR. SULLIVAN: You're right.

3 MS. AVERY: And that's the purpose of the
4 Subcommittee, but I don't think it's an option not to
5 address the under utilization of the long-term care beds in
6 the state of Illinois. So, that's what we're looking for
7 also.

8 CHAIRMAN WAXMAN: Totally agree. So my next
9 point before you rudely interrupted --

10 (Laughter)

11 CHAIRMAN WAXMAN: She knows I'm kidding. So,
12 therefore, then if there is this agreement -- which I'm
13 looking at some nodding faces, and either they're falling
14 asleep or they're agreeing with me. I'm not sure which.
15 The question then becomes, we need to do something about
16 the issue on the table. So, is there some research you
17 would like Staff to do? Is there some additional proposals
18 you would like Staff to look at and bring to our April
19 meeting? I mean, how do you want to address this issue so
20 that Alexis has something to take back to the Mother Board
21 or Courtney has something to take back to the Mother Board.

22 Tim?

23 MR. PHILLIPPE: I think probably it seems
24 dramatic, the reaction. If you've got a community where

1 this average census is 60 percent or 65 in that community,
2 they would say, "Well, that doesn't make any sense." So,
3 maybe it's more some gradual -- try it and kind of
4 gradually see change, because I think in general, the idea
5 that we have too many beds is recognized and it's confusing
6 in the process. Right? I think we all see we have too
7 many beds. Other states have processes where they
8 intentionally reduce the number of beds in their state.
9 You just have to -- what would be a sort of a start to see
10 how we work on it?

11 CHAIRMAN WAXMAN: Cece?

12 MS. CREDILLE: The premise from the
13 beginning -- and Alexis said it from the beginning -- is
14 that we are over bedded. Then if we leave the bed-need
15 formula the way it is and it creates more bed need
16 because -- which is exactly where Terry started, this takes
17 us nowhere in terms of what our obligation is for the
18 Subcommittee and actually beyond the long-term care walls.
19 We're not trying to create more beds out here, but if we
20 take these beds out, it creates a bed need and so we've
21 solved nothing, and we haven't infused capital into our
22 existing properties. We've given no relief to providers,
23 and it goes back to the buy/sell as an option for
24 redistribution of beds, in addition to looking at the

1 bed-need formula. But you can't -- I don't see how you can
2 do this with the existing bed-need formula. It solves
3 nothing.

4 CHAIRMAN WAXMAN: Pat?

5 MS. O'DEA EVANS: You know, it's very -- I've
6 understood and I've listened to Staff on how they utilize
7 the bed-need formula or would like to utilize it, and it's
8 been difficult because of -- you know, because of the
9 historical under/over use. But there's probably outliers
10 in this group of facilities that -- and there's probably
11 some that have historically been bed hoarding or whatever,
12 and I think those -- maybe that should be looked at in that
13 way, you know, in more of a -- are there some specific
14 areas that are really having difficulty with us, and is
15 there a way to kind of look at who is doing the bed
16 hoarding and where there is a need and we can see there is
17 a need and there's not enough beds? It's very theoretical
18 the way we're talking about it, when the reality is, we
19 have really real data, and we actually can pinpoint where
20 some of these problems are, instead of just talking about
21 it in some theoretical application.

22 MR. SULLIVAN: I think other states have tried
23 various ways of reducing beds, starting with moratorium,
24 which has been tried in a number of states. We could make

1 that part of the impact study, of how did your moratorium
2 work? A number of them have done that in relation to a bed
3 relocation program. There have been a number of states
4 that have tried bed repurchasing, where the State buys the
5 beds from the facility. Do I think that's going to happen
6 in Illinois? Not in a long time that I can see. However,
7 there also have been adjustments to the capital rate of the
8 Medicaid rate, based on reducing beds, as an incentive to
9 reduce beds, and if HFS is willing to give up seven and a
10 half million dollars of bed tax money, one would think that
11 you could find at least a pilot program of seven and a half
12 million dollars to say, "We'll buy beds back for seven and
13 a half million dollars." And, actually, it's not seven and
14 a half; it's \$15 million, when you include the federal
15 match. "If they're willing to give up that on beds that's
16 costing them nothing right now, and I'm not sure where
17 their logic was coming from, we're all for automatically
18 reducing beds, when it's going to cost them money and it
19 doesn't now."

20 But there are other states that have tried
21 different options in reducing beds, some successful, some
22 not. They've also been the -- grant transfer of beds,
23 changing it to something else, like assisted living or
24 whatever. But there have been other states that have done

1 something.

2 So, if you want different solutions, I think
3 states have tried things, and I think, you know, that could
4 be part of an impact study that could be reviewed, because
5 the reality is, we don't know how that would impact
6 Illinois, but I think there are other ways of approaching
7 this issue of over beddedness, including changing the
8 bed-need formula, that doesn't take a meat cleaver to the
9 entire system.

10 CHAIRMAN WAXMAN: Mike?

11 MR. SCAVOTTO: I hate to agree with Terry, but
12 I do. But I also want to commend Charles, because I think
13 that his study of -- his suggestion about a Twilight Zone
14 for beds is worth looking at. I just think we've got a
15 problem that is going to get more difficult today, and I
16 don't think we can solve today's problems with yesterday's
17 standards. We've got to get different thinking on this,
18 and I'm just as guilty as the next person. We've got to
19 come to grips with the fact that this is really a knotty
20 problem.

21 CHAIRMAN WAXMAN: Claire, have you done any
22 research on other states in terms of how -- when it comes
23 to eliminating beds?

24 MS. BURMAN: Yes, I have.

1 CHAIRMAN WAXMAN: Have you done one of your
2 great papers that I'm not remembering?

3 MS. BURMAN: I did one recently, yeah.

4 CHAIRMAN WAXMAN: Do we have it?

5 MS. BURMAN: I can distribute that, sure.
6 That's not a problem.

7 Just as an overall statement, I spoke to these
8 people over the phone. I didn't just send e-mails. I
9 spent a lot of time on the phone, and nobody is very happy
10 with what they've done so far, but you we might find
11 something that does work for Illinois. There's always that
12 possibility.

13 MR. FOLEY: What were some of the areas that
14 they were actually doing?

15 MS. BURMAN: One was mothballing the unused
16 beds, and if a need turned up in that Planning Area at a
17 future date, then the facility that gave up the beds had
18 first dibs on them, you know. That was seen as a carrot
19 approach, you know. Most of the states that I found
20 anything on do have moratoriums. They've had them for a
21 long time. A number of those do have some form of bed
22 buying, but there is a difference between eliminating too
23 many beds and the bed buying issue. The bed buying
24 redistributes beds; it doesn't eliminate the numbers. So

1 it's a different thing.

2 MR. FOLEY: Unless you put a ratio on it, like
3 two for one or something like that.

4 MS. BURMAN: You could do that. I believe
5 there's one state, if you're going to sell, then you had to
6 give up, I think, 10 percent of the number of beds that you
7 were selling. So they had kind of a double duty there.

8 CHAIRMAN WAXMAN: Can I ask one of the
9 historians, has Illinois ever had a moratorium?

10 MR. SULLIVAN: No.

11 CHAIRMAN WAXMAN: It's not been tried?

12 MR. SULLIVAN: Never been tried.

13 CHAIRMAN WAXMAN: Has it been talked about in
14 the past?

15 MR. SULLIVAN: Oh, my goodness, yes. It has
16 always been very controversial.

17 MR. FOLEY: There was one time an unofficial
18 moratorium. There was nothing going on in the nursing home
19 industry.

20 MR. SHEETS: Because the Board wasn't granting
21 any new CONs.

22 MR. FOLEY: So, an unofficial moratorium, so
23 to speak.

24 MR. SHEETS: I think Mike's point is, there's

1 two kind of beds here. Is there a bed in the nursing home
2 set up in a room somewhere, or is it a fictitious bed
3 that's now an office or something? And I know he's -- he
4 does a survey, but people -- I hate to say this -- don't
5 always tell the truth in the surveys. So, there might be a
6 better way to find out what beds are really set up.

7 CHAIRMAN WAXMAN: When your -- Toni, when
8 your staff visits a nursing home, is one of their questions
9 the number of beds in operation?

10 MS. COLON: Current census. We don't go -- we
11 don't request, you know, your licensure documentation. We
12 do check our database during our off-site preparation, to
13 determine licensed number of beds. We go in, we ask for a
14 current census to determine percentage. I would be glad to
15 forward information, if that is something you would be
16 interested in reviewing.

17 CHAIRMAN WAXMAN: Again, I have spent many
18 years in the nursing home industry, as some of you have,
19 and I know that licensed beds is a number, and I know that
20 offices became -- bedrooms became offices and therapy rooms
21 and those beds didn't exist, but the license still said
22 they do. So, you don't routinely check and see.

23 MS. COLON: We don't go around counting every
24 bed, no.

1 CHAIRMAN WAXMAN: And the obvious answer is,
2 if we said fill out this document and tell us, you know,
3 beds in storage versus offices, we'll never get a true
4 answer.

5 MS. COLON: They should be filling out their
6 cost reports at the end of the year. That information is
7 already provided on an annual basis, and it should add up.
8 I don't know if -- obviously, it doesn't. That's the topic
9 of conversation, but they're required to provide accurate
10 information on an annual basis.

11 CHAIRMAN WAXMAN: Mike, does any of your data
12 include cost reports?

13 MR. CONSTANTINO: No. We do our own survey.
14 The cost reports are available at HFS's web site. I don't
15 know how current they are.

16 MR. SULLIVAN: It's 2011, but it's based on
17 census; it's not based on set-up beds.

18 MR. FOLEY: The actual licensed beds.

19 MR. PHILLIPPE: One of the reasons this is
20 complicated is because we have mixed goals. We don't
21 really know why we're doing it.

22 CHAIRMAN WAXMAN: Are you talking about this
23 Committee?

24 MR. PHILLIPPE: No, not the Committee, this

1 whole one point. We don't have a consensus on why we're
2 doing it. So, from the Staff's side, I think partly it's
3 for good planning purposes. It's hard to have a decent
4 process when you can't plan, really. I think that's the
5 big issue that they're talking about.

6 CHAIRMAN WAXMAN: Hold on. Is that the
7 issue, a planning issue?

8 MS. KENDRICK: (nods)

9 MR. PHILLIPPE: I can see that. But the
10 second one is, say, for some not-for-profit providers, it
11 also feeds into it can be a consumer issue. We can say the
12 beds are -- there's not a bed need, because they're not
13 being used, but somebody else would say, "I really would
14 like to meet that consumer need. Those are old-fashioned
15 buildings. They no longer meet the consumer need. I have
16 an innovative program I would like to create in that
17 community, but you won't let me, because these other people
18 are tying up the beds." So that's kind of the opposite
19 fear, Cece. Once we do this and it creates more beds out
20 there, someone is going to come along and say, "I have
21 something I want to do to meet a need in the community that
22 those beds weren't being used before," and then I think
23 there could be a concern on another side.

24 The third goal -- really, some people say

1 nationally there are just too many nursing home beds and
2 it's good public policy just to reduce the number. If you
3 reduce the number -- Phyllis is not here. Somebody said
4 this before. Utilization of nursing goes up when there's
5 more beds. In the states that have fewer licensed beds,
6 they put more resources into other levels of care and other
7 services, and so there's some people from public policy
8 that would like to see the number of beds go down so that
9 we would have a forward program in the state of Illinois.
10 Probably there are some providers who don't want to do
11 that, because it would hurt whatever they're doing.

12 I do think it would be helpful to know the
13 goal, because if we're clear on what we're trying to
14 accomplish, along with the background information, we could
15 come to an agreement faster.

16 CHAIRMAN WAXMAN: Gerry?

17 MR. JENICH: May I ask a question of the
18 Staff? Is there any cost savings associated with this? Is
19 there --

20 MS. KENDRICK: For our fund; like for
21 ourselves?

22 MR. JENICH: When it's a Planning Board or
23 some other State agency, is there any cost implication one
24 way or the other?

1 CHAIRMAN WAXMAN: Well, so far, the only
2 implications I've heard is loss of revenue to the State.

3 MR. JENICH: So, you have that issue, right?
4 And on the provider's standpoint -- I know I've read some
5 of the previous meeting minutes, and Eli was kind enough to
6 kind of fill me in on the past couple meetings and some of
7 the conversations. From the provider's standpoint, the
8 changing of those bed counts generates legal fees for the
9 providers. Would the State consider offsetting those, if
10 this were to go through?

11 MR. CONSTANTINO: What legal fees?

12 MR. JENICH: For example, a lot of nursing
13 home operators are financed through HUD or some other
14 mechanism. The way those agreements are written today,
15 they're cross-collateralized with banking agreements and
16 HUD, and the banks don't agree with how that language needs
17 to be written. So, any change in the licensed capacity on
18 those documents requires legal fees to be generated by
19 those two entities, and it doesn't matter if it's one bed
20 or a hundred beds, and it doesn't matter if it's one
21 building or whatever. Every one of those costs somewhere
22 between five and a hundred thousand dollars in legal fees,
23 just to change the documents that would correlate to bed
24 count.

1 MR. SULLIVAN: Those lawyers.

2 (Laughter)

3 MS. AVERY: That's the first I've heard of
4 that in terms of a legal fee, and we haven't gotten direct
5 answers from the person that was going to meet with us.
6 That meeting didn't happen. Because that was some of the
7 feedback that we heard around this Subcommittee, was this
8 tie to HUD, but we haven't gotten a direct response to it.
9 But not tied to the legal fee.

10 MR. JENICH: It might be something for the
11 research committee to take a look at, because those are
12 real dollars.

13 MS. AVERY: We have been trying to meet with
14 them, but it just hasn't happened.

15 MR. SULLIVAN: Courtney, I can put you in
16 touch with the key people at HUD.

17 MS. AVERY: Okay.

18 CHAIRMAN WAXMAN: That's certainly a
19 significant point that I don't think anybody has
20 considered. Thank you, Jerry. Is that from experience,
21 Jerry?

22 MR. JENICH: Absolutely, and Under Lien 32
23 and -- Lien 232 in the HUD program, the requirements now
24 are very, very restrictive, and approval has got to be

1 done. Documents have to correlate to one another.

2 MR. SCAVOTTO: That's interesting. More and
3 more deals are being done by HUD.

4 CHAIRMAN WAXMAN: That I'm aware of.

5 Mr. Sheets, are you in agreement?

6 MR. SHEETS: With everything except maybe the
7 dollar figure.

8 (Laughter)

9 MR. PHILLIPPE: My attorneys are less
10 expensive. They don't cost me that much.

11 MR. SHEETS: Jerry is right. It's HUD now.
12 It's been that way for years and years, and under the new
13 program that Jerry talked about, HUD has so many different
14 documents. Your bank deposits for Medicaid go to a certain
15 bank account. If it gets rolled into another bank account
16 HUD has -- there are agreements on that bank account, and
17 it's all tied to the number of the beds as a collateral.
18 So, when you change the collateral, you're in default under
19 the documents.

20 CHAIRMAN WAXMAN: Did I hear you say that
21 Medicaid payments have to be deposited in a certain place?
22 Did I hear you say that?

23 MR. SHEETS: Yes.

24 CHAIRMAN WAXMAN: Okay.

1 MR. SULLIVAN: Yes.

2 CHAIRMAN WAXMAN: We're coming upon the
3 bewitching hour, as Courtney was so kind to remind me.

4 MS. AVERY: Because I know you would like to
5 stay on time.

6 CHAIRMAN WAXMAN: I do like to stay on time.
7 We need to give some direction to Staff. So,
8 our direction is, at this point in time, this committee
9 is -- not willing is the wrong word -- not suggesting that
10 you move forward with that recommendation as it's written.

11 MS. AVERY: So what we will take back to the
12 Board --

13 CHAIRMAN WAXMAN: The Mother Board.

14 MS. AVERY: What would your recommendation be?

15 CHAIRMAN WAXMAN: And that's, I guess, what I
16 need to get a concensus from this group on, what our
17 recommendation is, either in terms of a specific
18 recommendation or a suggestion of what we would like to see
19 Staff prepare for the April meeting.

20 MR. SULLIVAN: I think Claire has already done
21 some research, and I wonder if we follow the same process,
22 that based on Claire's research to this Committee, that
23 maybe we do a connection with an academic institution to
24 say what is the impact of the different schemes other

1 states have tried, as Claire has investigated, and Claire
2 has already gotten some feedback about what works and
3 doesn't work, and maybe an academic institution can come up
4 with a suggestion of ways of changing either the bed-need
5 formula or ways of reducing beds in this state that doesn't
6 cost the State significant amounts of money or providers,
7 that is an incentive program to reduce beds. And maybe
8 that's where I'm heading. What kind of incentives are
9 there to help providers reduce beds?

10 CHAIRMAN WAXMAN: Some other -- I can't
11 adjourn this meeting until Juan has his 25 words, by the
12 way.

13 MR. MORADO: Okay.

14 CHAIRMAN WAXMAN: He always has 25 words.
15 He's a man of a few words. Is there anything you may wish
16 to add, Juan?

17 MR. MORADO: I think you ran a great meeting.
18 I appreciate everyone coming today. We had a great
19 turnout. This is a lively debate, and I look forward to
20 the next one.

21 MR. SULLIVAN: Three more words.

22 CHAIRMAN WAXMAN: Thank you, thank you.

23 So, Terry has thrown several suggestions out.
24 We've already talked about one with Claire sending her work

1 out.

2 Claire, did Terry throw some things out that
3 will require you to add some additional material to what
4 you've already gathered, or do you already have them?

5 MS. BURMAN: No, I think I have everything
6 that is available.

7 CHAIRMAN WAXMAN: Okay. So the two -- through
8 this group, you'll get it out to the Committee in the
9 proper time. Anybody else wish to add to Terry's thoughts
10 about what we would like to look at in April?

11 MR. PHILLIPPE: Just going to my point of
12 goals of what we're trying to accomplish, if somebody could
13 kind of write up what you hope to get out -- if we are
14 eliminating the beds, whatever, what is the outcome we're
15 looking for in the public policy process? Because it is my
16 understanding that while we're trying to accomplish this,
17 we might find some middle ground to accomplish the same
18 goal. I'm not talking about a huge paper.

19 CHAIRMAN WAXMAN: Pat?

20 MS. O'DEA EVANS: Just had a question. We had
21 four facilities close. How many beds were taken out of
22 inventory?

23 MS. AVERY: Are you talking about the
24 State-owned facilities?

1 MS. O'DEA EVANS: When we were talking about
2 in our report, it said there were four operators.

3 MR. SULLIVAN: Five.

4 MS. O'DEA EVANS: Or five operators. Did we
5 reduce beds then?

6 MR. CONSTANTINO: Oh, yes.

7 MS. AVERY: We remove them from the inventory.

8 MS. O'DEA EVANS: How many were removed, was
9 my question, total?

10 (Pause)

11 MR. CONSTANTINO: Maybe between five and six
12 hundred.

13 MS. O'DEA EVANS: Okay.

14 CHAIRMAN WAXMAN: Does this group feel, based
15 upon the economy going into 2013 and maybe 2014, that there
16 will be more homes closing?

17 MR. JENICH: Yes.

18 CHAIRMAN WAXMAN: How many would you guess?

19 MR. FOLEY: There's a crisis right now,
20 because there's a mandate out there where facilities have
21 to be fully sprinkled by August of this year, and that
22 could, in fact, realistically close a facility. That's why
23 I was hoping we could do something with this bed sell, you
24 know, because we talked about this last year, hoping that

1 with the bed sell, it might keep some of those providers in
2 business. But now, obviously, I think there's like 200
3 facilities out there that are not fully sprinkled. Is that
4 right, Terry?

5 MR. SULLIVAN: Um-hum.

6 MR. FOLEY: Some of those -- I don't know --
7 could, in fact, be forced to close.

8 MR. CONSTANTINO: Is CMS going to grant a
9 waiver?

10 MR. SHEETS: Published a rule to allow two
11 years for the waiver. The rule talks about your economic
12 ability, and going forward, you have to prove up that --
13 your typical waiver where there's a hardship.

14 MR. CONSTANTINO: So you think that when
15 August 3rd, 2013 comes around, CMS will grant waivers to
16 these facilities?

17 MS. COLON: No. They made it very clear that
18 they will not grant waivers. That is not the way in which
19 they prefer to go. What will happen on August 13th, 2013
20 is that if a facility is out of compliance, they will have
21 their enforcement cycle that's initiated, have their
22 opportunity to correct within that enforcement period. But
23 CMS has made it very clear -- I've not heard, and I'm sure
24 I would be first to hear if they're granting waivers. That

1 is not the goal. State of Illinois has approximately 287
2 facilities that have been identified as outliers of not
3 being fully sprinklered, throughout the state. What we're
4 doing within our program, if anybody is interested, is
5 we're going through our database to determine specifically
6 what is creating the non-compliance. We're hoping to
7 reduce that number. What we are finding is that they were
8 downgraded, many of these facilities. For example, five
9 sprinkler heads were not working; they just needed five
10 sprinkler heads replaced. They were downgraded to
11 partially sprinklered, but they have the capacity to be
12 fully sprinklered with correcting those five sprinkler
13 heads, and we'll be providing that information to all
14 associations. So, we're hoping to minimize that number,
15 but we will provide that information. But, nonetheless, we
16 are aware that that may -- because of the capital
17 improvement and investment that would need to take place to
18 bring them up to compliance, facilities may decide to fold
19 their cards for that operation.

20 CHAIRMAN WAXMAN: Thank you, Toni.

21 Terry?

22 MR. SULLIVAN: I was surprised that only five
23 facilities closed and discontinued last year. My previous
24 recollection from Public Health data -- and I haven't

1 looked at it in a few years -- is that it generally
2 averaged about 12 facilities a year over a 10-year period,
3 and in the back of my mind, in 1995 we had a 114,000
4 licensed beds. We're down to 100,000? I mean, things have
5 been shutting down, you know, not as rapidly as occupancy,
6 but beds are significantly closing at a thousand, fifteen
7 hundred beds a year since 1995. I'm not saying that the
8 problem can be solved in twenty years, but, you know, I
9 think it's too big of a drastic step to say let's take
10 14,000 beds out of the system. The marketplace does have
11 an impact.

12 CHAIRMAN WAXMAN: Mr. Sheets, did you have
13 something?

14 MR. SHEETS: Well, there's a -- you know, in
15 February, CMS proposed a rule on sprinklers; so, it's to
16 give everyone a two-year period.

17 CHAIRMAN WAXMAN: The criteria is really
18 short, isn't it, or difficult to meet?

19 MR. SHEETS: It is, but up until February, it
20 was always, from CMS, if you're not in compliance, you're
21 done. So, there's been a rush, and I know that Public
22 Health has been reviewing a lot of drawings, update of
23 sprinklers, and there's a concern that a lot of facilities
24 aren't going to get done, and they're in the middle of it.

1 So, I don't think that's going to cause a lot of buildings
2 to close. I agree with Terry, though, that, you know,
3 there's a lot of long-term care wings in hospitals that
4 have closed down and there's a lot of smaller facilities or
5 CCRC's that maybe reduced their -- sometimes they reduce
6 their nursing component in the community. So, there's a
7 lot of downsizing that goes on on a regular basis.
8 Actually closures? That's a much more difficult thing.
9 Usually, like I said before, the government is closing
10 them.

11 MR. FOLEY: The numbers Mike had are numbers
12 he received obviously from Licensure. Right, Mike?

13 MR. CONSTANTINO: Yes.

14 MR. FOLEY: So if there are more, he was not
15 notified.

16 CHAIRMAN WAXMAN: Toni, you're aware of
17 downsizing, as well as closures, aren't you? So you
18 would -- so, you would have that information.

19 MS. COLON: We can provide information. I
20 mean, there's -- downsizing as far as facilities that are
21 requesting to close or reduce their number of beds, we
22 receive all of that information.

23 CHAIRMAN WAXMAN: And would you send it out
24 to --

1 MS. COLON: Sure.

2 CHAIRMAN WAXMAN: So his numbers should
3 reflect the fact that a CCRC has taken skilled beds out.
4 That should be counted already, right?

5 MR. CONSTANTINO: Yes.

6 CHAIRMAN WAXMAN: Okay. So, we've gotten sort
7 of a global from Terry Sullivan, and a few other people
8 have chimed in of what we're looking for from Staff. Can
9 we be a little more concrete of what we might want in
10 addition from them for April?

11 We want goals. We want to know what you're
12 really looking for, so we can get a handle on it. Planning
13 seems to be the goal, but is that the only goal you're
14 looking at? Is there a different methodology of bed count?

15 MR. CONSTANTINO: It's planning, Mike.

16 CHAIRMAN WAXMAN: Okay. Claire has some data
17 that she wants to share. Is there anything else before we
18 call it a day? Very productive day. Juan is correct. I
19 think it was a good, good meeting today. I hope all of you
20 feel the same. I see puzzled looks.

21 MS. AVERY: For clarification, what we need to
22 take back to the Board is a firm, concrete recommendation
23 from you all to take to the Board. So, this is one of the
24 initiatives, and this is what we hear when applicants come

1 to the table. Some of you around the table have been
2 denied, based on there not being a need in the area, and
3 out of the mouths of the applicants are, "But there is a
4 need. These beds, they're not set up. They can't be set
5 up in 24 hours." So, we're kind of getting the backlash of
6 all of that, and that's where this came from, because we're
7 hearing it from you all, that we can't get into the market
8 because people have ghost beds or whatever term you want to
9 use. So, that's what we're trying to do, is clean this up
10 so operators can come in that want to come in and provide a
11 service, have the opportunity to do so. So what we need is
12 a concrete recommendation from you all.

13 CHAIRMAN WAXMAN: Do you need a motion?

14 MS. AVERY: A recommendation or a motion.

15 CHAIRMAN WAXMAN: Anyone want to put a motion
16 together that Courtney and the Staff can take back to the
17 Mother Board?

18 MR. SULLIVAN: That the Long-Term Care
19 Subcommittee recommends investigating other alternatives
20 than just an across-the-board bed reduction program and
21 that we put into place investigative steps to pursue that,
22 but that we do not recommend the current legislative
23 proposal on across-the-board bed reduction.

24 CHAIRMAN WAXMAN: Do I have a second to that

1 motion?

2 MS. O'DEA EVANS: Second.

3 CHAIRMAN WAXMAN: We have a motion and
4 second. Any discussion on that motion?

5 (Pause)

6 MS. O'DEA EVANS: I think there's been some
7 pretty productive and thoughtful discussion about the
8 impact of doing an across-the-board reduction, and I think
9 it should be presented that way, that we're talking about
10 reducing revenue, we're talking about having some real
11 issues coming forward soon with the Medicaid managed care,
12 and that there's a lot of pieces unknown out there about
13 the financial impact of facilities having to go through
14 this process. I think that's quite a bit of information to
15 bring back on why this isn't just a theoretical exercise or
16 formula.

17 CHAIRMAN WAXMAN: Any other discussion or
18 comments on the motion? Otherwise I call for a vote. All
19 in favor?

20 ("Ayes" heard)

21 CHAIRMAN WAXMAN: Any opposed?

22 (No response)

23 CHAIRMAN WAXMAN: Can't find any opposed.
24 Any abstaining?

1 (No response)

2 CHAIRMAN WAXMAN: Okay. Then are you okay
3 with what you got?

4 MS. AVERY: Yes.

5 CHAIRMAN WAXMAN: Okay. April 23rd; it's a
6 Tuesday; 10:00 a.m. to -- we might add an hour on.

7 Any other business to bring before the
8 Committee?

9 (Pause)

10 CHAIRMAN WAXMAN: Then I need a motion to
11 adjourn.

12 MR. PHILLIPPE: So moved.

13 MR. RAIKES: Second.

14 CHAIRMAN WAXMAN: We have a motion and second.
15 All in favor?

16 ("Ayes" heard)

17 CHAIRMAN WAXMAN: Any opposed?

18 (No response)

19 CHAIRMAN WAXMAN: Any abstain?

20 (No response)

21 CHAIRMAN WAXMAN: Meeting adjourned.

22

23 END TIME: 2:15 p.m.

24

1 CERTIFICATE OF REPORTER

2

3 I, KAREN K. KEIM, RPR, CRR, a Certified Court
4 Reporter, do hereby certify that the proceedings in the
5 above-entitled cause were taken by me to the best of my
6 ability and thereafter reduced to typewriting under my
7 direction; that I am neither counsel for, related to, nor
8 employed by any of the parties to the action, and further
9 that I am not a relative or employee of any attorney or
10 counsel employed by the parties thereto, nor financially or
11 otherwise interested in the outcome of the action.

12

13

14

KAREN K. KEIM

15

CRR, CSR-IL, RPR, CCR-MO

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